# HEALTH and COMMUNITY SUPPORTS CONTRACT

between

DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF DISABILITY AND ELDER SERVICES

and

<<GENERIC>> COUNTY

January 1, 2007 – December 31, 2007

# Health and Community Supports Contract
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**Health and Community Supports Contract**[1]

**between**

**Department of Health and Family Services**
**Division of Disability and Elder Services**

**and**

**<<Generic>> County**

This contract is entered into for the period January 1, 2007 to December 31, 2007 by and between the State of Wisconsin represented by its Division of Disability and Elder Services, of the Department of Health and Family Services, hereafter DHFS, whose principal business address is One West Wilson Street, P.O. Box 7850, Madison, Wisconsin, 53707-7850, and <<Generic>> County's Care Management Organization, hereafter CMO, whose principal business address is <<Department>>, <<Address>>.

Whereas, DHFS wishes to purchase certain long-term care and health care services, under the State Medicaid Plan approved by the Secretary of the U.S. Department of Health and Human Services pursuant to the Social Security Act, and as authorized by s. 46.284 (2) of the Wisconsin Statutes (Stats.).

The CMO is an organization certified by DHFS, pursuant to s. 46.284 (3) Stats., to make available to members, in consideration of periodic fixed payments, certain long-term care and health care services.

Now, therefore, DHFS and CMO agree as follows:

## I. CMO Governance and Consumer and Member Involvement

### A. CMO Governing Board

The CMO shall have a governing board that provides input to the CMO decision-making process. When a CMO takes action that is not consistent with the input of the governing board, the CMO Director shall provide the governing board with a written justification for the decision and the rationale for diverging from the governing board recommendation. The CMO governing board shall meet the following specifications:

1. *Diversity*
   The board shall reflect the ethnic and economic diversity of the CMO service area.

2. *Consumer Representation*
   At least one-fourth of the members of the board shall be older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates who are representative of the CMO's members.

[1] Definition of terms used in this contract are contained in Addendum I, page 120.

3. *Separation from Eligibility/Enrollment*
   The CMO will assure the CMO's separation from the eligibility determination and enrollment counseling functions. The separation shall meet criteria established by DHFS in accordance with s. 46.285 Stats., and applicable Federal guidelines.

4. *Family Care District*
   If the CMO is operated by a Family Care district, as described in s. 46.2895 Stats., the district shall meet the requirements for governance in s. 46.2895 Stats.

**B. Local Long-Term Care Council**

The Local Long-Term Care Council (LLTCC) is responsible for general planning and oversight functions which are specified in s. 46.282 (3) Stats. The CMO shall cooperate with and provide assistance to the LLTCC to successfully complete LLTCC duties. At a minimum, the CMO shall perform the following:

1. *Information from the CMO*
   The CMO shall provide the LLTCC with information on appeals and grievances, enrollments and disenrollments, agreements and memorandums of understanding related to eligibility and enrollment functions, provider networks, and service utilization.

2. *Recommendations from the LLTCC*
   The CMO shall receive and give consideration to the LLTCC's recommendations on the following:

   a. The CMO provider network in regard to developing a network of providers that assures the services in the FC benefit are accessible to its projected membership, are geographically convenient and provide a desirable level of quality;

   b. Any proposed changes to the Health and Community Services Contract which shall be reviewed with the LLTCC by the CMO prior to signing the upcoming year's contract;

   c. Whether to seek authority to offer optional services which are provided through Medicaid fee-for-service (see Article III.A. (5), *Services Coordinated Through Medicaid Fee-For-Service* (page 19), for the list of services) and strategies to offer such services if recommended as part of the LLTCC's review of the provider network;

   d. Strategies for improving interactions with any other agency related to eligibility and enrollment process to achieve better accuracy and timeliness; and strategies for improving the CMO based on a review of the CMO's Appeal and Grievance Reports.

## II. CMO Functions: Enrollment and Disenrollment

### A. Approval of Marketing/Outreach Plans and Materials

The CMO agrees to engage only in marketing/outreach activities that are pre-approved in writing, as follows:

1. *Plan Approval by DHFS*
   If the CMO engages in marketing/outreach activities a plan describing those activities must be approved in writing by DHFS before the plan is implemented.

2. *DHFS Approval of Marketing Material*
   The CMO shall submit to DHFS for approval all marketing/outreach materials that describe the Family Care program or benefits, including mailings sent only to members, prior to disseminating the materials. Marketing/outreach materials are defined in Addendum I., Definitions (beginning on page 120).

   Problems and errors identified by DHFS, insofar as they pertain to the prohibited practices listed in this Article under subsection 5, below, must be corrected by the CMO when they are identified.

   Approval of marketing/outreach plans and materials will be reviewed by DHFS in a manner which does not unduly restrict or inhibit the CMO's marketing/outreach plans and materials, and which considers the entire content and use of the marketing/outreach materials and activities. Specific language approved by DHFS may be used again or in other media without being resubmitted for approval.

3. *CMO Operated by a County*
   For any CMO operated by a county, all marketing and outreach materials must indicate that the CMO is a county agency and that the county is also operating the resource center.

4. *Review by Consumer Representatives*
   All marketing/outreach materials must be reviewed by a group that includes consumer representatives to assure materials are understandable and readable for the average consumer.

5. *Prohibited Practices*
   The following marketing/outreach practices are prohibited:

   a. Practices that are discriminatory;

   b. Practices that seek to influence enrollment in conjunction with the sale of any other insurance product;

   c. Direct and indirect cold calls, either door-to-door or telephone;

d. Offer of material or financial gain to potential members as an inducement to enroll;

e. Activities and materials that could mislead, confuse or defraud consumers;

f. Materials that contain false information;

g. Practices that are reasonably expected to have the effect of denying or discouraging enrollment;

h. Marketing/outreach activities that have not received written approval from DHFS; and,

i. Activities or other materials that make any assertion or state that the CMO is endorsed by CMS, the Federal or State government, or any other entity.

6. *Marketing/Outreach Materials and Activities*
Marketing/outreach materials (as defined in Addendum I) that describe the Family Care program and benefits, if developed, shall be distributed to all consumers eligible for enrollment in the CMO in the service area. DHFS will determine what marketing/outreach materials and marketing/outreach activities are subject to the requirements of this contract.

**B. Member Information**

1. *General Requirements*

a. Member information shall be in accordance with accessibility of language requirements in Article VII.C., *Accessibility of Language*, page 90.

b. The CMO shall have an updated member handbook and provider network directory approved by DHFS before the effective date of this contract.

c. The CMO shall provide members a member handbook and provider network directory annually at a minimum.

d. The CMO shall provide the resource center and enrollment consultant with Department approved member handbooks and provider network directories for the purpose of dissemination to potential CMO members.

e. The member handbook and the provider network directory cannot contain any assertion or statement that the CMO nor any of its contracted providers are endorsed by CMS, the Federal or State government, or any other entity.

2. *Member Handbook*
A member handbook shall be reviewed and approved using an internal CMO advisory body (as defined under Article III.E. (2) (j), *Sensitivity to Population*, page 46).

The CMO shall provide members periodic updates to the member handbook as needed to explain changes in any of the minimum information requirements (below) at least thirty (30) days in advance of the effective date of the change. Such changes must be approved by DHFS prior to distribution.

The handbook at a minimum will include information about:

a. Being a member of the CMO. This information shall include the nature of membership in a care management organization as compared to fee-for-service;

b. Obtaining assistance for members with cognitive impairments to review materials about membership in the CMO;

c. Location(s) of the CMO facility or facilities;

d. Hours of service;

e. Information on services in the LTC benefit package, including:

    i. List of services in the LTC benefit package;

    ii. Each members right to select from the CMO's network of providers, and any restrictions on member rights in selecting providers;

    iii. Ability to change providers;

    iv. Any cost sharing related to these services; and,

    v. The availability of private rooms in residential settings and an explanation of the potential costs associated with private room residency.

f. Information on Medicaid covered services not in the LTC benefit package that remain fee-for-service and procedures for obtaining these services (for members who are Medicaid beneficiaries), including:

    i. The list of these services;

    ii. How and where to obtain these services;

    iii. How transportation is provided; and,

    iv. Any cost sharing related to these services.

g. Information regarding the maximization of Medicare benefits including:

i. The expectation that Medicare benefits will be elected by members who are currently enrolled in Medicare Parts A and/or B and that the Medicare benefit is maximized; and,

ii. That if the member is currently enrolled in Medicare Parts A and/or B and chooses not to elect to use his or her Medicare benefits, the CMO may refuse to pay for costs that Medicare would otherwise cover.

h. The right to receive services from culturally competent providers, and information about specific capacities of providers, such as languages spoken by staff, etc.;

i. Information on Self-Directed Supports, as specified in Article III.B. (2), *Self-Directed Supports*, page 31;

j. Information on the extent to which members may obtain services outside of the provider network;

k. Policies and procedures for advance authorization of services, and on the members' ability to obtain services necessary to achieve outcomes;

l. Policies on use of after hours services and obtaining services out of the CMO's service area;

m. Information on voluntary enrollment, voluntary disenrollment, and involuntary disenrollment;

n. Members' rights and responsibilities as defined by DHFS;

o. Information about independent advocacy services available as sources of advice, assistance and advocacy;

p. Appeal and grievance process:

i. What constitutes an appeal, grievance, or fair hearing request;

ii. How to file appeals, grievances and fair hearing requests, including timeframes and the member's ability to appear in person before the CMO personnel assigned to resolve appeals and grievances;

iii. Information about the availability of assistance with the appeal and grievance process, and fair hearings;

iv. Toll-free numbers that the member can use to register a appeal or submit a written grievance by telephone;

v. Specific titles and telephone numbers of the CMO staff who have responsibility for the proper functioning of the process, and who have the authority to take or order corrective action;

vi. Assurance that filing an appeal or grievance or requesting a fair hearing process will not negatively impact the way the CMO, its providers, or DHFS treat the member; and,

vii. How to obtain services during the grievance and fair hearing processes.

q. Procedure for members to have input on changes in the CMO's policies and services;

r. Notice of right to obtain information on results of member surveys;

s. Information regarding estate recovery provisions applying to CMO membership;

t. If the CMO is operated by a county, indication that the CMO is a county agency and that the county also operates the resource center; and,

u. Information on the Family Care Member Outcome Interview process, including the possibility that the CMO will ask the member to participate.

3. *Provider Network Directory*
A provider network directory shall be reviewed and approved using an internal CMO advisory body (as defined under Article III.E. (2) (j), *Sensitivity to Population*, page 46).

The provider network listing shall include:

a. Provider name (individual practitioner, or agency as appropriate);

b. Provider location, and telephone number;

c. Services furnished by the provider;

d. Any known provider limitations in accepting new CMO members (if a preferred provider is not accepting new members, the CMO assist the member in obtaining an alternate provider); and,

e. Accessibility of the provider's premises (if the member will be receiving services at the provider's premises).

**C. Enrollment**
The CMO shall comply with the following related to enrollment:

1. *Open Enrollment*
   Conduct open enrollment consistent with the Resource Center Access Plan approved by DHFS. All applicants shall be enrolled provided the individual meets eligibility requirements as defined in Addendum I., *Definitions* (page 120). Practices that are discriminatory or that could reasonably be expected to have the effect of denying or discouraging enrollment are prohibited.

2. *Voluntary Enrollment*
   Enrollment in the CMO is a voluntary decision on the part of an applicant who is determined to be eligible.

3. *Enrollment While Eligibility is Pending*
   The CMO shall have an MOU (Memorandum of Understanding) or other written agreement with the resource center that describes the circumstances in which the CMO will provide services to an individual who is functionally eligible but whose financial eligibility is pending, and that includes a process for the resource center to inform the individual that if he/she is determined not to be eligible, he/she will be liable for the cost of services provided by the CMO.

   The CMO will not receive a per member per month payment for an individual during the time eligibility is pending. If and when eligibility is established, the CMO will receive a per member per month payment retroactively to the date indicated as the "effective date of enrollment" on the Enrollment Request form, or the Family Care eligibility certification start date, whichever is later, up to a maximum of ninety (90) calendar days of serving the person while eligibility was pending. The effective date of enrollment entered on the Enrollment Request Form shall also be no earlier than the date on which an individual signs an agreement to accept services during the period of pending eligibility.

   If the individual is determined not to be eligible, the CMO may bill that individual for the services the CMO has provided. The CMO shall pay providers for services which were provided and prior authorized by the CMO. The CMO shall not require providers to collect payment from the individual.

   The timelines for completion of the Individual Service Plan (ISP) and comprehensive assessment shall be the same as those indicated in Article III.B. (5) and (6) on page 35.

**D. Disenrollment**

The Access Plan, developed in collaboration with the resource center and economic support, shall be the agreement between entities for the accurate processing of disenrollments. The Access Plan shall ensure that the CMO is not directly involved in processing disenrollments, that enrollments are accurately entered on CARES so that correct capitation payments are made to the CMO, and that timely processing occurs which will reduce administrative costs to the CMO and other service providers for claims processing.

The CMO shall comply with the following related to disenrollment:

1. *Voluntary Disenrollment*
   All members shall have the right to disenroll from the CMO without cause at any time. If the member expresses a desire to disenroll from the CMO, the CMO shall make a referral to the resource center for options counseling with the member, after which the member will indicate a preferred date for disenrollment. The date of voluntary disenrollment cannot be earlier than the date the individual last accepted services authorized by the CMO. If the member requests a disenrollment date prior to the last date services were accepted from the CMO, the earlier date can be assigned with agreement from the CMO. The resource center will notify the CMO and Economic Support Unit about the member's final disenrollment decision as soon as possible but no later than one business day following the member's decision to disenroll. The CMO shall continue providing services until the disenrollment date.

2. *CMO Influence Prohibited*
   The CMO shall not counsel or otherwise influence a member due to his/her life situation (e.g., homelessness, increased need for supervision) or condition (e.g., person with profound mental retardation, person with AIDS) in such a way as to encourage disenrollment.

3. *Ineligibility*
   The member will be disenrolled if he/she loses his/her eligibility. Loss of eligibility occurs when:

   a. The member fails to meet functional or financial eligibility requirements;

   b. The member initiates a move out of the CMO service area (see Article III.A. (15), page 23);

   c. The member is incarcerated;

   d. The member is admitted to an Institution for Mental Disease (IMD) and is no longer eligible for Medicaid;

   e. The member fails to pay, or to make satisfactory arrangements to pay, any cost share amount due the CMO after a thirty (30) calendar day grace period;

   f. The member dies; or,

   g. The member is ineligible for Medicaid as an Institutionalized Individual consistent with 42 CFR 435.1008 and as defined in 42 CFR 435.1009.

4. *Involuntary Disenrollment*
   The CMO's intention to involuntarily disenroll a member shall be submitted to DHFS for a decision and shall be processed in accordance with Article IV.G., *Department Appeal and Grievance Resolution Process*, and/or Article IV.H., *Fair Hearing*

*Process* (beginning on page 58). When the CMO submits a request for disenrollment to DHFS, the CMO shall also inform the member of the CMO's request for disenrollment and refer the member to the resource center for options counseling and potential transition back to the fee-for-service system. The CMO shall continue to serve the member until the effective disenrollment date.

5. *Continuity of Services*

   a. Until the date of disenrollment, members are required to continue using the CMO's providers for services in the LTC benefit package. The CMO shall continue to provide all needed services in the LTC benefit package until the date of disenrollment.

   b. To facilitate a member's reinstatement in the fee-for-service system (for members who are Medicaid beneficiaries), the CMO shall assist the member in obtaining necessary transitional care through appropriate referrals and by making member records available to new providers.

## E. Enrollment/Disenrollment, and Re-Enrollment Process

1. *Monitoring by DHFS*
   The CMO shall permit DHFS to monitor enrollment and disenrollment practices of the CMO under this contract.

2. *Interactions with Other Agencies related to Eligibility and Enrollment*

   a. The CMO shall fully cooperate with other agencies and personnel with responsibilities for eligibility determination, eligibility re-determination, and enrollment in the CMO. This includes but is not limited to the resource center, economic support and the enrollment consultant. The CMO shall participate with these agencies in the development and implementation of an Access Plan that describes how the agencies will work together to assure accurate, efficient and timely eligibility determination and re-determination and enrollment in the CMO. The Access Plan shall describe the responsibility of the CMO to timely report known changes in members' level of care, financial and other circumstances that may affect eligibility, and the manner in which to report those changes.

   b. The CMO shall jointly develop with the resource center protocols for voluntary and involuntary disenrollments, per contract specifications.

   c. The CMO shall support members in meeting Medicaid reporting requirements as defined in HFS 104.02 (6). Members are required to report changes in circumstances to Economic Support within 10 days of the occurrence of the change.

3. *Discriminatory Activities*
   Enrollment continues as long as desired by the eligible member regardless of changes in life situation or condition, until the member voluntarily disenrolls, loses eligibility, or is involuntarily disenrolled according to terms of this contract. The CMO may not discriminate in enrollment and disenrollment activities between individuals on the basis of life situation, condition or need for long-term care or health care services. The CMO shall not discriminate against a member based on income, pay status, or any other factor not applied equally to all members, and not base requests for involuntary disenrollment on such grounds.

4. *Dates of Enrollment and Disenrollment*
   The CMO shall enroll and begin serving individuals as of the effective date of enrollment on the Enrollment Request form, or the Family Care eligibility certification start date, whichever is later. An enrollment date greater than 90 days in the past will be entered if a data entry error was made by the Medicaid fiscal agent or by the ES worker and the individual meets all eligibility requirements. Requests for retroactive enrollment dates, greater than three (3) calendar months in the past are subject to Department review and require submission of documentation of evidence that the individual meets all program requirements, prior to approval.

   a. A voluntary disenrollment shall be effective on the date indicated on the disenrollment form as effective disenrollment date, but not later than the first day of the second month following the month in which the enrollee files the request.

   b. An involuntary disenrollment shall be effective on the date approved by DHFS as the disenrollment date, but no later than the first day of the second month following the month in which the CMO filed the request. In order to allow time for the member to grieve an involuntary disenrollment decision from DHFS, DHFS shall retain the disenrollment form for fourteen (14) calendar days after the CMO and member has been notified by DHFS before forwarding it to the Medicaid fiscal agent or economic support worker to process the disenrollment. If the member files an appeal of an involuntary disenrollment decision to the DHA fair hearing process within fourteen (14) calendar days, disenrollment shall be delayed until the appeal is resolved.

   c. If the member dies, the date of disenrollment shall be the date of death.

   d. Loss of eligibility resulting in disenrollment shall have the effective dates as identified in i. and ii. below, but no later than the first day of the second month following a month in which the enrollee files the request.

      i. If a CMO member is planning to or has moved out of state, complete a Family Care CMO disenrollment form and send copies of the form to both the resource center and economic support unit. The date of disenrollment shall be the date the move occurs.

If an individual who has been a CMO member for less than six months has moved or is moving to another county in Wisconsin, complete a Family Care CMO disenrollment form and send copies of the form to both the resource center and the economic support unit. The date of disenrollment shall be the date the move occurs.

If an individual who has been a CMO member for at least six months moves to a COP waiver county within Wisconsin, and the person desires to continue long-term care services, the procedures outlined in the most recent DHFS memo, "Policy and Procedure for Permanent Moves between Family Care Counties and COP/Waiver Counties" shall be followed.

If the person has been incarcerated or has been admitted to an IMD, the CMO should report this change in circumstance to the economic support unit as this change may result in a loss of Medicaid eligibility.

ii. If a CMO member loses eligibility for a reason other than those identified in i., above, the last day of eligibility shall be set according to adverse action logic in the Client Assistance for Reemployment and Economic Support System (CARES). The disenrollment date will be the date eligibility ends. The CMO shall continue to provide services to the member through the date of disenrollment.

5. *Level of Care Re-Determinations*
The CMO shall develop procedures to assure that all members have a current and accurate level of care as determined by the Long-Term Care Functional Screen (LTC FS). Level of care re-determinations may only be completed by an individual trained and certified to administer the LTC FS. If the trained screener administering the LTC FS is an employee, or under direct supervision of the CMO, no Medicaid Administration reimbursement may be claimed for administration of the screen.

The responsibility to assure that all members have a current and accurate level of care shall, at minimum, include:

a. An annual re-determination of level of care no later than the last day of the same month in which the most recent functional screen was completed. The member must receive an "intermediate" or "comprehensive" rating for continued enrollment in the CMO, unless the individual is eligible under the grandfathering criteria as defined in Addendum I., *Definitions* (beginning on page 120). If the level of care re-determination is not completed in the designated timeframe, the CMO is required to inform Economic Support of the lack of functional eligibility determination according to change reporting requirements identified in Article II.E. 2. *Interactions with Other Agencies related to Eligibility and Enrollment* (page 10).

b. A re-determination of level of care whenever a member's condition changes significantly.

c. If the trained screener administering the LTC FS is an employee, or under direct supervision of the CMO, no Medicaid Administration reimbursement may be claimed for administration of the screen.

6. *Accuracy of Information*
The CMO shall not knowingly misrepresent or knowingly falsify any information on the LTC FS. The CMO shall also verify the information it obtains from or about the individual with the individual's medical, educational, and other records as appropriate to ensure its accuracy.

7. *Standards for Staff Qualifications*
The CMO shall ensure that staff members who administer the functional screen satisfy the following standards:

a. Education and Experience
A staff member who administers the functional screen shall meet all the applicable training requirements specified by the Department for the effective term of this contract and shall have either:

i. A license to practice as a registered nurse in Wisconsin pursuant to s. 441.06 Stats. or a Bachelor of Arts or Science degree, preferably in a health or human services related field, and at least one year of experience working with the type of individuals, such as the elderly or individuals with developmental or physical disabilities, who constitute one of the target populations of the CMO; or, in the event that the staff member lacks such a degree and such experience,

ii. Approval from the Department to administer the functional screen, where such approval is discretionary on the part of the Department, must be requested by the CMO no later than fourteen (14) calendar days after the staff member begins to administer the screen, must be based either on the staff member's post-secondary education and experience or on a written plan prepared by the CMO, and submitted to the Department, to give the staff member formal and on-the-job training to develop the skills required to administer the screen, and where such approval may not waive the requirement found in Subsection b (below) that no staff member shall be allowed to administer the functional screen on individuals unless and until he or she passes the post test designed by the Department and is certified by the Department as a functional screener.

b. Test Required For Screeners
Individuals administering the functional screen must pass the post test designed by the Department and shall be certified as a functional screener by the Department before being allowed to administer the functional screen on individuals.

8. *Policies and Procedures Concerning Functional Screen Quality*
   The CMO shall develop and implement Department-approved policies and procedures to ensure the accuracy and timeliness of all of the functional screens done by the CMO or CMO contractors. These policies and procedures shall include provisions for the CMO to do at least all of the following:

   a. Designate a staff member who meets all of the requirements to administer the functional screen to be a screen lead and have this screen lead do the following:

      i. Act as the liaison between the Department and the CMO with respect to all of the issues involving the quality of the screens done by the CMO;

      iii. Attend all of the screen lead meetings held by the Department; and,

      iii. Randomly sample completed screens to make sure that they are accurate and complete.

   b. Have all of the screeners read and follow all of the instructions for the functional screen issued by the Department and all of the updates issued by the Department to these instructions;

   c. Train, mentor, and monitor new screeners;

   d. Work with the Department to maintain an accurate, complete, and up-to-date list of all of the staff members who are screeners;

   e. Consult with the Department about cases where it is proving unusually difficult for the CMO to complete an accurate screen on an individual or to interpret all or part of a completed screen;

   f. Have the screen lead and other screeners participate in all of the training on the screen that the Department requires them to participate in;

   g. Have all of the screeners complete at least once during the effective term of this contract the hypothetical case scenario exercise created by the Department. If the average score for all screeners, or any individual screener, is below seventy (70) percent on any one of the following three screen components: Activities of daily living, instrumental activities of daily living; and health related services, then the CMO will implement any improvement projects or correction plans the Department requires to ensure the accuracy and thoroughness of the screens done by its screeners; and,

   h. Discuss with the Department what changes, if any, it might need to make in the way that it does its screening if the Department concludes, after analyzing data from screens that the CMO has done, that there are or may be problems with the way it is doing its screening and communicates this conclusion to it in the

quarterly reports or in the annual report that the Department prepares on screen data and sends to the CMO or in any other way at any other time.

9. *Department Deadlines for Submission and Approval*
   The CMO shall submit policies and procedures concerning the quality of the screens that it does prior to the end of this contract period (as specified in Addendum IX.,*CMO Certification and Re-Contracting*, page 166). The CMO will inform the Department if the policies and procedures have been revised since their last submission.

10. *Timeline for Department Approval*
    The Department will review the functional screen policies and procedures within forty-five (45) calendar days of receipt and notify the CMO whether it approves them in whole or in part. In the event the Department does require changes, the CMO shall resubmit the material with the requested changes to the Department no later than twenty-one (21) calendar days after being notified by the Department of the changes needed. The Department shall notify the CMO whether it approves these policies and procedures with the requested changes no later than twenty-one (21) calendar days after receiving the requested changes.

11. *Notification of Changes in Functional Eligibility Criteria*
    The Department will notify the CMOs of any changes in administrative code requirements that result in changes to the LTC FS algorithms or logic in determining functional eligibility for the FC program.

## III. CMO Functions: Services

Members shall be provided with high-quality long-term care and health care services that are from appropriate and qualified providers, that are fair and safe, that serve to maintain community connections, including work, and that are cost effective.

The CMO will inform members of the full range of services in the LTC benefit package. The CMO will provide a range of services to meet the needs and outcomes of its members, as identified in the comprehensive assessment process (described in this Article under B. (6), *Initial Comprehensive Assessment*, page 35).

The CMO is not restricted to providing only the services in the LTC benefit package listed below. Family Care members have a right to request any covered service, whether or not the service has been recommended as necessary or appropriate by a professional or the interdisciplinary team responsible for coordinating their care.

In developing service plans in consultation with members, members' authorized representatives and informal supports, the CMO interdisciplinary team may decide that other services, treatments or supports are more appropriate or likely to result in better outcomes than the services in the LTC benefit package (e.g., exceptional housing needs, acupuncture,

or membership in a fitness club). The per member per month payments made to the CMO will not be increased or decreased when additional or alternative services are provided.

Members shall receive services in the long-term care benefit package where they live, including:

1. Members own home, including supported apartments.

2. Alternative residential settings:

   - State Certified Residential Care Apartment Complex (RCAC).
   - Community-Based Residential Facility (CBRF) as described in Addendum I, *Definitions* (beginning on page 120).
   - Adult Family Homes.

3. Nursing Facilities or ICFs/MR.

The CMO shall provide services during periods of temporary absence as described this Article under III.A. (15), *Services During Periods of Temporary Absence*, page 23).

The CMO shall provide support for self-directed care as described in this Article under B. (2), *Self-Directed Supports* (page 31).

**A. Provision of Services in the LTC Benefit Package**

1. *Services for Members at the Comprehensive Level*
   The CMO shall promptly provide or arrange for the provision of all services in the LTC benefit package, consistent with Individual Service Plan (ISP) (described in this Article under B. (8), *Individual Service Plan and Member-Centered Plan Development*, page 37, and as defined in Addendum X., *Service Definitions: Family Care Benefit Package*, page 167). The services include:

   - Adaptive Aids (general and vehicle) [1]
   - Adult Day Care [1]
   - Alcohol and Other Drug Abuse Day Treatment Services (in all settings) [2]
   - Alcohol and Other Drug Abuse Services, except those provided by a physician or on an inpatient basis [2]
   - Care/Case Management (including Assessment and Case Planning) [1, 2]
   - Communication Aids/Interpreter Services [1]
   - Community Support Program [2]
   - Consumer Education and Training[1]
   - Counseling and Therapeutic Resources [1]
   - Daily Living Skills Training [1]
   - Day Services/Treatment [1]
   - Durable Medical Equipment, except for hearing aids and prosthetics (in all settings)[2]

- Home Health [2]
- Home Modifications [1]
- Housing Counseling[1]
- Meals: home delivered [1]
- Medical Supplies [2]
- Mental Health Day Treatment Services (in all settings) [2]
- Mental Health Services, except those provided by a physician or on an inpatient basis, and except for Coordinated Community Services (CCS) [2]
- Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and Institution for Mental Disease [2]
- Nursing Services [2] (including respiratory care, intermittent and private duty nursing) and Nursing Services [1]
- Occupational Therapy (in all settings except for inpatient hospital) [2]
- Personal Care [2]
- Personal Emergency Response System Services [1]
- Physical Therapy (in all settings except for inpatient hospital) [2]
- Prevocational Services [1]
- Relocation Services [1]
- Residential Services: Certified Residential Care Apartment Complex (RCAC) [1], Community-Based Residential Facility (CBRF) [1], Adult Family Home [1], Children's Foster Care and Treatment Foster Care. [1, 3]
- Respite Care (for care givers and members in non-institutional and institutional settings) [1]
- Specialized Medical Supplies [1]
- Speech and Language Pathology Services (in all settings except for inpatient hospital) [2]
- Supported Employment [1]
- Supportive Home Care [1]
- Transportation: Select Medicaid covered (i.e., Medicaid covered Transportation Services except Ambulance and transportation by common carrier[2]) and non-Medicaid covered [1]
- Vocational Futures Planning [1]

[1] The services listed in this subsection with a (1) suffix are defined in Wisconsin's CMS (Centers for Medicare & Medicaid Services) approved waivers: #0367 and #0368 under s. 46.281 (1) (c) Stats., and as otherwise specified in this contract.

[2] The services listed in this subsection with a (2) suffix are defined under s. 49.46 (2) Stats., and HFS 107 Wis. Adm. Code; as further clarified in all Wisconsin Medicaid Program Provider Handbooks and Bulletins, CMO Contract Interpretation Bulletins (CIBs) and as otherwise specified in this contract.

[3] This service is listed in this subsection with a (3) suffix is defined in under s. 49.46 (1) Stats.

2. *Services in the Long-Term Care Benefit Package for Members at the Intermediate Level*
   The CMO shall promptly provide or arrange for the provision of all services in the LTC benefit package, consistent with the Individual Service Plan, with the following exception: members at the intermediate level, who are not residing in a nursing facility or ICF/MR at the time of enrollment, do not have access to long-term care (i.e., care for longer than ninety (90) calendar days) in a nursing facility or ICF/MR. Prior to admission when possible or not later than three (3) business days following admission to a nursing facility or ICF-MR a member at the intermediate level of care must have the LTC Functional Screen updated by a certified screener to determine whether changes in the member's long-term health and care needs are consistent with the comprehensive level of care. The Individual Service Plan is updated based upon review of the changes in care needs and the preferences of the member. The member must be rescreened to determine level of care within sixty (60) calendar days following discharge from the nursing home or ICF/MR.

3. *Services in the Long-Term Care Benefit Package for Members Eligible as Grandfathers*
   The CMO shall promptly arrange for the provision of all services in the LTC benefit package consistent with the Individual Service Plan. If the care needs of an individual eligible for Family Care as a grandfather increase, the individual must be rescreened to determine whether the individual meets the intermediate or comprehensive level of care. Members eligible as grandfathers have access to the full benefit package and all rights of membership in the CMO.

4. *Changes in Mandated Services*
   Changes to Medicaid covered services mandated by Federal or State law, and amendments to Wisconsin's CMS approved waivers subsequent to the effective date of this contract will not alter the services in the LTC benefit package for the term of this contract, unless agreed to by mutual consent, or unless the change is necessary to continue to receive Federal funds or due to action of a court of law.

   a. *Per Member Per Month Payment Adjustment*
      If any change in services in the LTC benefit package occur which are mandated by Federal or State law and incorporated into this contract, DHFS shall adjust the per member per month rate accordingly.

   b. *Changes by Mutual Agreement*
      DHFS will give the CMO thirty (30) calendar days notice of any such change that reflects service increases, and the CMO may elect to accept or reject the service increases for the remainder of the term of this contract. DHFS will give the CMO sixty (60) calendar days notice of any such change that reflects service decreases, with the right of the CMO to dispute the amount of the decrease within that sixty (60) calendar day period. The CMO has the right to accept or reject service decreases for the remainder of the term of this contract.

c. *Date of Change Implementation*
The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit DHFS's ability to modify this contract for changes made necessary by the State Budget.

d. *Notification to Members*
The CMO shall notify members within ten (10) business days after the effective date of changes in the type of services in the LTC benefit package.

5. *Services Coordinated Through Medicaid Fee-For-Service*
For members who are Medicaid beneficiaries, the following Medicaid services remain fee-for-service:

- Alcohol and Other Drug Abuse Services provided by a physician or in an inpatient setting
- Audiology
- Chiropractic
- Crisis Intervention
- Dentistry
- Eyeglasses
- Family Planning Services
- Hearing Aids
- Hospice
- Hospital: Inpatient and Outpatient, including emergency room care (except as indicated in list of covered services beginning on page 16)
- Independent Nurse Practitioner Services
- Lab and X-Ray
- Mental Health Services provided by a physician or in an inpatient setting
- Optometry
- Pharmaceuticals
- Physician and Clinic Services (except as indicated in list of covered services beginning on page 16)
- Podiatry
- Prenatal Care Coordination
- Prosthetics
- School-Based Services
- Transportation: Ambulance and transportation by common carrier

6. *Authorization of Services and Utilization Management*
The CMO shall have documented service authorization policies and procedures for processing requests for initial and continuing authorizations of services and for determining approval or denial of services. Policies must take into account anticipated long-term social and quality of life issues. Such consideration includes implications for independent living, support for the least restrictive residential setting for the member, and skill acquisition for the member to perform activities of daily living.

These policies require review and approval by DHFS before the effective date of this contract. These policies shall be stated in the Member Handbook.

7. *Payment for Services*
   The CMO is responsible for payment of all authorized services in the LTC benefit package provided to all members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports (see Article VIII.E., *Disenrollment*, page 99) generated for the month of coverage.

8. *Necessity or Appropriateness of Services*
   The CMO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, disability or condition. The CMO shall not deny services necessary to reasonably and effectively achieve long-term care outcomes identified in the comprehensive assessment as well as those necessary to assist the member to be as self-reliant and autonomous as possible. Disputes between the CMO and members about the necessity of services are resolved through the grievance process in Article IV.F., *CMO Grievance System* (beginning on page 51). The determinations made through the grievance resolution process will be based on whether the services meet the definition of "Services Necessary to Achieve Outcomes" in Addendum I. *Definitions*, starting on page 120.

9. *Direct Requests by a member for a Service from the Interdisciplinary Team*
   When a member requests a service from a team member the CMO shall direct the team through written policies and procedures to:

   a. Promptly determine whether the request is to be authorized by the interdisciplinary team or whether the request must be referred outside the team for review, on the basis of review criteria that is approved by the state, (see number 12. below for processing requests outside the team);

   b. If the team is authorized by the CMO to provide or arrange the requested service without referring the request to anyone else, the team must use standardized decision making policies and procedures when processing requests for services that have been approved by the Department. (Requests for approval of the Resource Allocation Decision Method (RAD), as developed and disseminated by DHFS, when used by the interdisciplinary team and, including the member, will be approved by DHFS as a service authorization policy.);

   c. Acknowledge receipt of the request and explain to the member the process to be followed in processing the request;

   d. Assist the member as needed in completing forms or taking other necessary steps to process the request;

   e. For requests that the team is authorized to provide or arrange, assure that any such requests result in either a prompt decision by the team to approve or to disapprove

provision of or authorization of the service (based on either the RAD and/or other Department approved decision-making method);

f. When the CMO requires that additional CMO employees (e.g., supervisor) be involved in decision-making about a member request for service, the CMO employee shall:

   i. Join with the interdisciplinary team;

   ii. The team shall use the RAD or other approved decision-making method; and,

   iii. The member's interdisciplinary team shall make the final decision taking into consideration the recommendations of the CMO employee;

g. For requests that must be referred outside the team for authorization or approval, assure that such a referral occurs promptly.

10. *Process Direct Requests that are Determined to be not Necessary or Appropriate*
If the team is authorized by the CMO to provide or arrange the requested service without referring the request to anyone else and the team determines that the service is not necessary or appropriate and therefore declines to provide or authorize the service, the CMO shall:

a. Assure that the decision is made in consultation with appropriate health care professionals who have appropriate clinical expertise in treating the member's condition or disease.

b. Give the member written notice of any decision by the team to deny a request, or to authorize a service in an amount, duration, or scope that is less than requested. (Service authorization decisions not reached within the timeframes specified below constitute a denial and therefore require a written notice). Written notice must be given on the date that the timeframes expire. (The notice must meet the requirements of Article IV.F. (3), *Notice of Action*, page 53).

c. Notify the requesting provider of the authorization decision. Notices to providers need not be in writing.

d. Make decisions on direct requests for services and provide notice as expeditiously as the member's health condition requires and within any state-established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for the service, with a possible extension of up to fourteen (14) additional calendar days, if the member, or the provider, requests extension.

11. *Authorization Limits*
The CMO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for the purpose of utilization management, provided the services

furnished can reasonably be expected to achieve long-term care outcomes as defined in Addendum I., Definitions, beginning on page 120.

12. *Authorization or Approval Decisions Made Outside the Interdisciplinary Team*
For authorization or approval decisions that the member's immediate team is required to refer to anyone else (including referring the request to the team's immediate supervisor or a larger team of social service coordinators or registered nurses), and authorization or approval requests that are made by a member (or on behalf of a member) or by a provider to the CMO's utilization management review system, the CMO shall:

    a. Have in place and follow Department approved written policies, procedures and review criteria for making authorization or approval decisions. The review criteria used for decisions on coverage, or necessity and appropriateness shall be clearly documented, based on reasonable evidence or a consensus of relevant practitioners, and regularly updated.

    b. Specify information required for service authorization or approval decisions, have mechanisms to ensure consistent application of review criteria for service authorization or approval decisions, and consult with the requesting provider when appropriate.

13. *Timeframe for Expedited Authorization Decisions*

    a. Policies shall specify time frames for responding to requests for initial and continued determinations as expeditiously as the member's situation requires and within State-established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if the member, or the provider, requests extension.

    b. For cases in which a provider indicates, or the CMO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CMO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. The CMO may extend the 72-hour time period by up to fourteen (14) calendar days if the member requests extension.

    c. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a professional who has appropriate expertise in treating or managing the member's condition or disease.

    d. All service requests that are denied, limited, or discontinued shall be recorded, along with the disposition. Aggregate data on service requests that are denied,

limited, or discontinued are compiled for use in quality assessment and monitoring and are available upon request by DHFS.

e. The CMO shall communicate to providers, upon request, criteria used for review and approval of specific services.

f. The CMO does not prohibit providers from advocating on behalf of members within the utilization management process.

g. The CMO shall provide that compensation to individuals or entities that conduct utilization management or prior authorization activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue services necessary to achieve outcomes to any enrollee.

14. *Notice of Decisions*
The CMO shall provide written notification to the member when a decision is made to deny or limit a member's request for a service; or to terminate, reduce, or suspend a current service that is less than requested; or to deny payment for a service. Written notices are required when the CMO limits or denies any requested services unless the service is provided through the Medicaid fee-for-service program.

Service authorization decisions not reached within the timeframes specified above under subsections (10) and (13) (beginning on page 21), constitute a denial and are thus require a written notice. Written notice must be given on the date that the timeframes expire. (The notice must meet the requirements of Article IV.F. (3), Notice of Action (page 53).

The CMO shall provide written notification to the provider when a decision is made to not act on a claim (i.e., pay or deny) for services in the timeframe previously agreed upon with the provider. (See Article V.C. (5), *Appeals to the CMO and Department for Payment/Denial of Providers Claims*, page 75), for related information.)

15. *Services During Periods of Temporary Absence*
Family Care services are provided during a member's temporary absence from the CMO service area in accordance with Medicaid rules as specified in HFS 103.03 (3) and HFS 104.01 (6) Wis. Adm. Code. If a member asks the CMO to provide long-term care services during a temporary absence from its service area, the CMO shall conduct two tests to determine whether to provide the services:

a. Request economic support to do a residency test to determine whether the member is still considered a resident of the Family Care county.

- If no, the member is no longer a resident, loses eligibility and must be disenrolled.

- If yes, the member remains a resident, the CMO must go on to the second test.

b. Test whether a cost-effective plan for achieving the member's outcomes and assuring the member's health and safety during the absence can be developed using the RAD method:

- Is there a reason, related to the member's long-term care outcomes, for the member to be out of the CMO service area (could include education, vacation, extended vacation, i.e., over-wintering, etc.)?

- Is there a way for the CMO to effectively arrange and manage the member's services during the absence? Factors to consider:

  – Duration of absence;
  – Distance from CMO;
  – Availability of providers; and,
  – Ability to monitor the care plan directly, through contracting or other arrangements.

- Is there an effective way to arrange and manage the member's services during the absence that is cost-effective? Factors to consider:

  – Cost in comparison to effectiveness in achieving the member's outcomes;
  – Cost in comparison to the member's care plan costs when in the service area;
  – CMO staff time and effort in comparison to time and effort when in the service area; and,
  – Duration of absence.

c. If the CMO decides no, it cannot establish a cost-effective care plan for achieving a member's outcomes and assuring health and safety during the absence, it shall seek Department approval for involuntarily disenrollment. In considering whether to allow involuntarily disenrollment, the Department will expect the CMO to demonstrate that it is unable to continue to meet the member's long-term care outcomes and assure the member's health and safety with reasonable cost and effort. The member will be given the opportunity to rebut this contention and demonstrate that her/his long-term care outcomes can be met and health and safety assured with reasonable cost and effort, which could include a SDS plan.

d. If the CMO decides yes, it can establish a cost-effective care plan for achieving a member's outcomes and assuring health and safety during the absence, it must do so.

16. *Billing Members*

The CMO, its providers and subcontractors will not bill a member for services in the LTC benefit package that received advanced authorization from the CMO and were provided during the member's enrollment period in the CMO, except as provided for in the 1915(c) waiver post-eligibility treatment of income. This provision pertains even if:

a. The CMO becomes insolvent;

b. DHFS does not pay the CMO;

c. DHFS or the CMO does not pay the provider that furnishes the services under a subcontractual, referral or other arrangement; and,

d. Payment for services furnished under a subcontract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the CMO provided the service directly.

In the event of the CMO's insolvency, the CMO shall not bill members for debts of the CMO.

The CMO, its providers and subcontractors shall not bill a member for co-payments and/or premiums for services in the LTC benefit package under this contract and provided during the member's period of CMO enrollment. This provision shall continue to be in effect if the CMO becomes insolvent. See Article II.C. (3), *Enrollment While Eligibility is Pending* (page 8), for related requirements.

17. *Cost Sharing*

a. The CMO is responsible for collection of the member's monthly cost-share. The CMO's collection of monthly cost-share from waiver eligible Family Care participants is subject to Family Care waiver policy. In addition, the CMO is responsible for collection of the individual spend down amount for a Family Care Group C waiver eligible person.

b. Economic support calculates a member's total Group C spend down obligation. Out of pocket medical remedial expenses paid by the member count towards satisfying that total obligation and reduce the amount of spend down the CMO is to collect from the member.

c. The Department will ensure that a waiver eligible Family Care participant is not required to pay any amount in cost share which is in excess of the average cost, as determined by DHFS, of waiver services in a given month for all CMO waiver participants in the same target group.

d. The CMO is responsible for the ongoing monitoring of the cost share/monthly Medicaid waiver Group C spend down amounts of its members and reporting changes in those amounts to the Economic Support Unit within ten (10) days of the change. In addition, the CMO shall report a member's admission date to a hospital and/or skilled nursing facility, when that admission is anticipated to last thirty (30) days or more to Economic Support in order to determine any cost share associated with institutionalization. The CMO is also responsible for knowing

what the member's ongoing medical/remedial expenses are and reporting changes in those amounts to the ES.

e. Individuals who have been found to meet no Family Care financial eligibility criteria but who, after discussion with the resource center, elect to further explore eligibility, as a private pay person, may purchase case management from the CMO in the form of a comprehensive assessment and care plan.

   i. Following the CMO's completion of the comprehensive assessment and development of a care plan (paid for by the applicant), the CMO compares the person's actual care plan costs to the individual's maximum cost share obligation.

   ii. Should the person's actual care plan costs reveal to be greater than the individual's calculated maximum cost share obligation, the person may re-apply for Family Care as a Non-MA applicant using the determined actual care plan cost. The CMO refers the person back to the resource center who notifies ES of the actual care plan cost information.

   iii. If the reapplication finds that the person is eligible for Family Care, enrollment may be backdated up to three (3) months to cover the cost of the comprehensive assessment and care plan. However, this date can be no earlier than the day on which the CMO first began to serve the person. If the member has already paid the CMO the fee of the comprehensive assessment and care plan, the CMO reimburses the member by discounting her/his cost share. The CMO is responsible for payment of all Family Care benefit services provided on or after the retroactive enrollment date.

18. *DHFS Policy for Member Use of Personal Resources*
Family Care strictly prohibits billing members for any services included in the long-term care benefit package and necessary to achieve the member's individual outcomes. Any use of personal resources to enhance services or make a gift to a care provider must be wholly voluntary on the part of the consumer.

A CMO, CMO provider, or the State Medicaid program may only accept personal resources, in excess of cost share, from a member or the member's family or significant others, if such acceptance is consistent with the following:

a. Purchase of Enhanced Services -- The voluntary choice of a member or the member's family or significant others to purchase at fair market value, a service either: (a) not included in the Family Care benefit and, for Medicaid-eligible members, not covered by Medicaid, or (b) additional services included in the Family Care benefit that are not necessary to achieve member outcomes as documented in the ISP/MCP. Enhanced services may be purchased from the CMO, a CMO provider or an individual or agency associated with the CMO or its providers only when the procedures for ensuring that the purchase is voluntary that are outlined below are followed and documented in the member's case

record. The member or his/her family has the right, at any time, to revoke the consent for payment.

b. Gift (Transfer of Assets) -- The voluntary choice of a member or the member's family or significant others to transfer cash or something else of value to the CMO and/or provider of service as a recognition of or expression of gratitude for services to the member. This type of transfer of assets may be considered divestment of an asset and could lead to loss of Medicaid entitlement. (Refer to Addendum I., *Definitions*, starting on page 120 ) for the definitions of "Gift, "Something of Value," and "Voluntarily Transferred.")

c. Voluntary Payments, Prepayments or Repayments -- The voluntary choice of a member or the member's family or significant others to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, reduce potential claim in an estate. The payment is made to the state Medicaid program, which cannot accept more than what Medicaid has paid for that individual.

19. *CMO Procedures for Member Use of Personal Resources*

a. For purchase of enhanced services, CMOs and their providers may accept payment for enhanced services only if all of the following are documented in the member's case record:

i. That the payment is "pay the difference" in order to receive "added value" for either:

- A service or item that is not included in the Family Care benefit and, for Medicaid-eligible members, not covered by Medicaid; or,

- An additional service or item that is included in the Family Care benefit but that is not necessary to achieve the member's outcomes as documented in the ISP/MCP.

ii. That the CMO has assured that the purchase is a voluntary, informed choice, both initially and whenever there are significant changes in a member's individualized service plan or payments, by:

- Arranging for the CMO's member advocate to provide counseling to the member or the member's family or significant others regarding voluntary purchases, including that the member may revoke the consent for voluntary purchase at any time; and,

- Maintaining in the member's case record written confirmation from the CMO's member advocate providing counseling that the member and/or family received such counseling regarding payment for enhanced services.

b. A gift may be accepted by CMOs and their providers only if there is documentation in the member's case record that the CMO has assured that the gift was a voluntary, informed choice by:

   i. Arranging for the CMO's member advocate to provide counseling to the member or the member's family or significant others regarding voluntary gifts, including that the gift may be considered divestment of an asset and could lead to loss of Medicaid entitlement; and,

   ii. Maintaining in the member's case record written confirmation from the CMO's member advocate providing counseling that the member and/or family received such counseling regarding voluntary gifts.

c. The CMO shall refer to economic support a member or the member's family or significant others who wish to make voluntary payments to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, or reduce potential claim in an estate.

d. The CMO shall assure the CMO's member advocate that has provided counseling to members and their families about purchasing enhanced services or making contributions and has documented such counseling for the CMO has received training and understands:

   i. The types of situations when it might be appropriate for enrollees or families to make a payment; and,

   ii. How to determine whether the CMO is responsible for providing, without any payment, the services for which payment is sought; and,

   iii. Techniques for providing unbiased guidance to an enrollee or family on whether it is in their interests to make a payment; and,

   iv. The limits upon an enrollee's ability to make gifts, including rules of divestment and estate recovery; and,

   v. Member's option to make a voluntary repayment to the Medicaid program according to procedures identified in the Medicaid Eligibility Handbook, Appendix 6.1 – Estate Recovery Program.

e. The CMO shall report all payments received for enhanced services or as gifts to the Local Long-Term Care Council and the CMO Governing Board, and to the Department as part of the CMO quarterly financial report, as specified in Article X., *Reports and Data*, page 106.

20. *Private Pay Care Management*
    The CMO shall provide care management to private pay individuals as follows (Refer to Addendum I, *Definitions* (beginning on page 120) for definitions of "Care Management" and "Private Pay Individual"):

    a. *Care Management Available for Purchase*
    A care management organization shall offer care management services, at rates approved by DHFS, to private pay individuals who wish to purchase the services. A private pay individual may purchase from the CMO any types and amounts of case management. The types and amounts of care management and the cost of the services shall be specified in a written agreement signed by the authorized representative of the CMO and the individual purchasing the service or the person's authorized representative. The private pay care management agreement shall meet the following:

    i. The CMO's rates for private pay care management shall either:

    - Be no higher than the Medicaid targeted care management rates which are in effect at the time of providing the service; or,

    - Be approved by DHFS.

    ii. The CMO shall meet with the individual to achieve the following:

    - Fully review the specific aspects of care management the individual may purchase;

    - Clearly explain the cost of the service, and the billing and payment arrangements, including provisions for discontinuing service for failure to pay;

    - Clarify the specific care management tasks the individual agrees to purchase, the amount (e.g., number of hours) of care management that is being purchased, and who will be providing the care management;

    - Inform private pay individuals of their rights under Federal and State law (such as the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Americans with Disabilities Act) and their rights to have access to their service records in accordance with applicable Federal and State laws;

    - Inform private pay individuals that they are not eligible to purchase services from CMO's contracted providers at rates the CMO has negotiated for services it purchases for enrollees; and,

- Execute a written agreement containing the specific information described above. This agreement shall be signed by an authorized representative of the CMO and by the individual purchasing the service, or that person's authorized representative.

iii. The CMO's private pay care management service shall contain the following aspects at a minimum:

- A comprehensive assessment of the person's long-term care and health care needs;

- Development of a care plan to meet the needs identified in the comprehensive assessment, as well as the person's identified outcomes and lifestyle preferences. The care plan in no way limits the person's ability to purchase services at his or her own expense from service providers;

- Implementation and coordination of the care plan;

- As appropriate, either assisting the person in filing appeals and grievances with non-CMO service providers, or referring the person for advocacy services; and,

- Periodic reassessment, with appropriate updates to the care plan.

iv. Individuals purchasing private pay care management may access the CMO's appeal and grievance process only insofar as those appeals or grievances pertain to the care management provided by the CMO. Appeals or grievances against the CMO may be filed with or appealed to DHFS only insofar as those appeals or grievances pertain to the care management provided by the CMO. Appeals or grievances about other non-CMO services, which may be coordinated by the CMO, shall be filed with the service provider and if desired, with the appropriate regulatory agency.

b. *Limitations on Purchase of Other Services*

i. A private pay individual may not enroll in a care management organization, but, subject to pars. ii. and iii. may purchase services other than case management services, on a fee-for-service basis, from a care management organization.

ii. An individual who meets the definition under sub. (1) (b) 1. may purchase any service that the CMO provides directly and offers to the general public, at prices normally charged to the public.

iii. An individual who meets the definition under sub. a. 2.i. or ii. may purchase any service purchased or provided by the CMO for its members.

## B. Care Management

Note: Care Management for private pay individuals is covered in subsection 20, *Private Pay Care Management* (page 29), of this Article.

1. *Member Participation*

   To ensure optimum member participation in the Individual Service Plan (ISP) and Member-Centered Plan (MCP) development and updating, and that members take an active role in decision-making regarding the long-term care and health care services they need to live as independently as possible, the CMO shall provide the support requested or needed by members, their families or other representatives, when making informed health care decisions.

   Members shall receive clear explanations of (1) their condition, (2) risks involved in specific member preferences, (3) information on available treatment options or alternatives courses of care, (4), the full range of residential options, including in-home care, residential care and nursing home care when applicable, (5) the benefits, drawbacks and likelihood of success of each option, and (6) the possible consequences of refusal to follow the recommended course of care.

   The CMO shall inform members of specific conditions that require follow-up, and if appropriate, provide training in self-care, including factors that hinder full participation with prescribed treatments or interventions included in the ISP and the MCP.

2. *Self-Directed Supports*

   a. The CMO must present Self Directed Supports (SDS) as a choice to all members as specified in HFS 10.44 (6) Wis. Adm. Code. Specific responsibilities of the CMO are to:

      i. Continue to expand the variety of choices and supports available within SDS.

      ii. Collaborate with the Department in its efforts to develop systems for evaluating the quality of SDS, including members' experiences with SDS.

      iii. Collaborate with the Department in efforts to develop tracking systems and reports to document the number of members participating in SDS and the specific services and supports the members chose to self-direct.

      iv. As requested by the Department (as part of the quarterly report), submit periodic reports describing the CMO's progress in implementing SDS, any challenges or barriers faced.

v. Develop and implement a Department-approved policy and procedure describing conditions under which the CMO may restrict the level of self-management exercised by a member where the team finds the following:

- The health and safety of the member or another person is threatened.
- The member expenditures are inconsistent with the established plan and budget.
- The conflicting interests of another person are taking precedence over the desires and interests of the member.
- Funds have been used for illegal purposes.
- Negative consequences have occurred under other policies approved by the Department.

vi. The CMO's policy and procedure for limiting SDS shall be submitted to DHFS for approval within forty-five (45) days after the effective date of this contract.

b. It is the responsibility of the CMO interdisciplinary team to:

i. Provide information regarding the philosophy of SDS and the choices available to members within SDS. The information provided to members must include:

- A clear explanation that participation in SDS is voluntary, and the extent to which members would like to self-direct is the members' choice;
- A clear explanation of the choices available within SDS;
- An overview of the supports and resources available to assist members to participate to the extent desired in SDS; and,
- An overview of the conditions in which the CMO may limit the level of self-management by members, the actions that would result in the removal of the limitation, and the members' right to participate in the grievance process, as specified in Article IV., *Protection of Member Rights*, page 49.

ii. On a yearly basis, obtain a dated member signature on a form, or section of an existing form, where the member must:

(1) Check the statement below:

- My interdisciplinary team has explained the self-directed supports option to me. I understand that under this option I can choose which services and supports I want to self-direct. I understand that this includes

the option to accept a fixed budget that I can use to authorize the purchase of services or support items from any qualified provider.

(2) Check one of the two statements below:
- I accept the offer of self-directed supports and the interdisciplinary team is helping me explore that option; or
- I decline self-directed supports at this time but understand I can choose this option at any time in the future by asking my interdisciplinary team.

iii. Maintain the signed form required in section ii as part of the member's file.

iv. Work jointly with members during the assessment and planning process to ensure all key SDS components are addressed, including:

- What specific service/support do members want to self-direct;
- To what extent does members want to participate in SDS in this service area;
- Are there areas within the assessment that indicate that members may need assistance/support to participate in SDS to the extent they desire;
- Identification of resources available to support members as needed, including a thorough investigation of natural supports (e.g., family, friends, neighbors), as well as identifying the members' preferences regarding how/by whom these supports are provided;
- Identification of potential health and safety issues related to SDS and specific action plans to address these;
- Development of a budget for the support members have chosen to self-direct, and a plan that clearly articulates to what extent members would like to participate in the budgeting/payment process;
- Identification of what mechanism members have chosen to assure compliance with requirements for the deduction of payroll taxes and legally mandated fringe benefits for those employed by members (e.g., fiscal intermediary or co-employment agency); and,
- For members with guardians, the identification of the need for guardian training in the area of identification of member preferences, and member self-advocacy training.

v. Ensure all key SDS components are included in the member-centered plan, including:

- Desired outcomes related to SDS;

- Supports/resources that will be utilized to ensure members' participation in SDS to the extent they desire; and,

- Identification of potential health and safety issues, and a plan of action to address them.

vi. Ensure mechanisms are in place for ongoing check-in and support regarding the members' participation in SDS, including:

- Systems for ensuring member's expenditures are consistent with the agreed upon budget;

- Identification of any changes needed in the SDS budget or identified supports/resources;

- Check in regarding potential health and safety issues and the action plans developed to address them; and,
- Check-in regarding potential conflicts of interests--other persons' views taking precedence over the members' desires and interests.

3. *Interdisciplinary Team Composition*
The member receives case management through a designated interdisciplinary team which, at a minimum, consists of the member, a social service coordinator and a Wisconsin licensed registered nurse. The team utilizes appropriate additional specialized expertise for the initial comprehensive assessment, consultation, ongoing coordination efforts and other areas as needed. Except for existing employees holding a position comparable to a social service coordinator at the time of the initial contract effective date, the social service coordinator is required to have a minimum of a four-year bachelor's degree in the social services area (e.g., social work, rehabilitation psychology, etc.).

   The service coordinator and nurse shall have knowledge of community alternatives for the target populations served by the CMO and the full range of long-term care resources. Additionally, the service coordinator and nurse shall have specialized knowledge of the conditions of the target populations served by the CMO. The CMO shall establish a means that ensures ease of access for members to the interdisciplinary team.

4. *Individual Service Plan and Member-Centered Plan Development and Review*
CMO interdisciplinary teams are responsible for the preparation of the initial plans for members and for periodic reviews and updates of plans according to timeframes specified below to determine the appropriateness and adequacy of the services and to ensure that services furnished are consistent with the nature and severity of the member's disability. The DHFS shall review and approve a sample of CMO plans on a regular, ongoing basis. The CMO shall make all necessary documentation available to the DHFS or its designee either on-site at the CMO or off-site and a specified

location for this review. DHFS reviewers shall review available information about services, supports, time frames, staff responsible for service provision, and documentation of member preferences and needs to determine if all member needs are identified and addressed adequately, and shall approve those plans that address all of the member's needs. If the reviewer finds that services in a plan do not agree with the member's disabilities and needs in critical areas, or if basic member needs are overlooked in the assessment, a same-day referral shall be made to the DHFS and the CMO. If after further investigation, it is determined that the effect on the member is serious, the CMO shall take corrective action within specified time frames to ensure that the essential needs of the member are adequately addressed. In this circumstance, the plan will be pended for approval until identified problems are corrected. The DHFS shall track and trend review findings and provide a periodic report to the CMO. If a CMO is found to have an unfavorable trend towards pended approval of plans, the rate of review may be intensified.

5. *Initial Individual Service Plan (ISP)*
   The CMO is responsible for providing needed services beginning on the date of enrollment. Upon enrollment, the interdisciplinary team shall develop and implement an initial ISP, based on information received from the resource center and on the CMO's initial assessment of the member's needs. The initial ISP shall be developed by the CMO in conjunction with the member. The CMO shall contact the member within three calendar days of enrollment to develop an initial ISP and the initial ISP shall be signed by the member within ten (10) days of enrollment.

6. *Initial Comprehensive Assessment*

   a. *Procedure*
      The member is central to the assessment process. The CMO shall use an assessment protocol that includes a face-to-face interview with the member and that comprehensively assesses and identifies the member's needs and strengths, preferences, informal supports, and long-term care outcomes and identifies any ongoing conditions of the member that require a course of treatment or regular care monitoring. The interdisciplinary team shall encourage the active involvement of any informal supports in the assessment as desired by the member. The interdisciplinary team, member and informal supports shall jointly participate in completing a comprehensive assessment within thirty (30) calendar days of the enrollment date. If the CMO has been providing services to an individual while that individual's eligibility is pending, the comprehensive assessment shall be completed within thirty (30) calendar days of the date eligibility is established. If the CMO is unable to assess the member within this timeframe, the CMO must ensure that the reason why the member could not be assessed is documented in the member's record.

   b. *Documentation*
      The CMO shall use a standard format developed or approved by the DHFS for documenting the information collected during the Comprehensive Assessment. The CMO shall, document enough information in each area assessed to be able to

document the member's needs and ongoing conditions of the member that require a course of treatment or regular care monitoring and strengths. Information about the member's values, preferences and desired outcomes shall be recorded on the ISP/MCP document. The assessment format shall consist of at least the following:

i. Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs);

ii. Physical Health and Nutrition;

iii. Safety;

iv. Member Rights and Responsibilities, Autonomy and Self-Determination, including person's understanding of his/her rights, whether person has guardian or power of attorney for health care, preferences for executing advance directives, desire to self-manage care plan, determination of least restrictive setting if appropriate, personal preferences in regard to services, caregivers, and daily routine;

v. Personal values, including results of a life review or Futures Planning;

vi. Communication;

vii. Mental health and cognition including Alcohol and Other Drug Abuse (AODA) issues;

viii. Presence of informal supports;

ix. Social interaction and community integration;

x. Preferred living situation including identification of a member's preference for a private room for a person considering alternative residential services;

xi. Education and vocational activities; and,

xii. Economic Resources.

c. *Purpose*

The purpose of the comprehensive assessment report together with the Individual Service Plan (ISP) and Member-Centered Plan (MCP) is to provide a unique description of the individual to assist the interdisciplinary team, the member and any service provider or other authorized party to have a clear understanding of the needs, strengths and desires of the individual. The successful comprehensive assessment, MCP and ISP will provide information to allow any provider or authorized person to clearly identify the individual and the services and supports necessary to meet all individual needs and preferences and come to a common understanding of the approach the team is using to coordinate the member's care

and services. The criteria the Department will use to evaluate the comprehensive assessment, MCP and the ISP are timeliness, comprehensiveness, and relevancy to the member.

7. *Initial Comprehensive Assessment Appeals and Grievances*
   When the initial comprehensive assessment results in the member disagreeing with any of the assessment findings, the CMO shall discuss the issue with the member, and follow procedures outlined in Article IV.F., *CMO Grievance System* (page 51).

8. *Individual Service Plan and Member-Centered Plan Development*
   The interdisciplinary team shall encourage the active involvement of the member's informal supports in the development of the Individual Service Plan (ISP) and Member-Centered Plan (MCP). The interdisciplinary team, member and any informal supports shall jointly participate in the development of the ISP and MCP based on the comprehensive assessment within sixty (60) calendar days of the enrollment date. If the CMO has been providing services to an individual while that individual's eligibility is pending, the MCP and ISP shall be completed within sixty (60) calendar days of the date eligibility is established.

   For members with cognitive disabilities, the CMO shall ensure that family members, friends and other informal supports who know the member assist in conveying the member's preferences in the development of the MCP and ISP. In the development of the MCP and ISP, the CMO shall provide assistance as requested or needed to members in exercising their choices about where to live, with whom to live, work, daily routine, and services.

   The interdisciplinary team shall identify potential conflict of interest situations that affect the member's care and, either eliminate the conflict of interest or, when necessary, monitor and manage it to protect the interest of the member.

   a. *Individual Service Plan*
      The ISP is a document that lists services and supports provided or arranged by the CMO to address all needs identified in the functional screen and comprehensive assessment and all services and supports provided that are consistent with the nature and severity of the member's identified needs. The ISP shall contain at a minimum, the type of service or support to be furnished, the amount, the frequency and duration of each service (e.g., start and stop date), and the type of provider to furnish each service. It is a supplement to the Member-Centered Plan document described below.

   b. *Member-Centered Plan*

      i. *Purpose*
         Member-centered planning is an ongoing process that establishes how the members' identified strengths, skills and resources, informal, community and resources available through the Family Care benefit, will be used to achieve member defined outcomes. The member-centered planning process shall be documented in a single, comprehensive record of how LTC service

and support needs and acute and primary service needs are coordinated including how the plan is coordinated with community services and natural support systems that exist outside the CMO. The Member-Centered Plan (MCP) shall also specify the member's desired outcomes, steps/supports needed to achieve the outcome and the person(s) on the team responsible for tracking of steps/supports related to achieving outcomes identified on the plan. The criteria the Department will use to assess the effectiveness of Member-Centered Plans are: timeliness of the assessment and planning; continuity of assessment and planning; and member-centered approach to assessment and planning, which means that the outcomes identified in the plan are member-centered and member-directed.

ii. *Procedure and Documentation Requirement*s

The CMO interdisciplinary team shall be responsible for assuring that the MCP is developed and implemented in accordance with the following processes:

- The MCP shall be developed after interaction between the member, the members of the interdisciplinary team, and support persons identified by the member; and,

- The CMO shall use a standard format for documenting the information collected during the member-centered planning process. The Member-Centered Plan shall consist of at least the following:

  - Expected outcomes;
  - Member's goals and preferences;
  - Needs and preferences identified in the comprehensive assessment;
  - Type of residential setting;
  - Services or interventions to be provided, in order to meet the identified needs and honor the preferences identified in the comprehensive assessment;
  - Coordination of services outside the LTC benefit package;
  - The specific period of time covered by the MCP; and,
  - Party responsible for providing each service (including informal supports).

iii. *Documentation*

The CMO is responsible for furnishing services in the LTC benefit package based on the ISP/MCP, and coordinating all other services provided to the member from the date of enrollment. The ISP/MCP shall address comprehensive service needs regardless of whether the service is covered in the LTC benefit package or there is another source of payment (e.g., Medicare, Medicaid fee-for-service, private insurance).

In addition to informal supports, the interdisciplinary team shall actively involve providers, agencies and others identified in the ISP/MCP in

developing and revising the ISP/MCP. Involvement of participants shall be based on the preference of the member, and the parties' ability to contribute to the ISP/MCP regardless of provider type (e.g., primary care physician, psychiatrist).

The CMO shall document in the member record instances when the ISP/MCP differs from the member's preference, (e.g., the CMO substitutes a preferred service or support arrangement with another of comparable quality and efficacy) and the reason for not meeting the member's preference, and whether or not the member agrees with the substitution.

The CMO shall document in the member record instances when the member refuses a specific service or services. However, when a member refuses a service, the CMO must have a process for assuring that the member has been made aware of the risks, if any, that are associated with refusing a service(s), to the extent possible.

The ISP/MCP shall be reviewed with and signed by the member, or the member's authorized representative as appropriate, to indicate his/her agreement with the ISP/MCP. The CMO shall provide the member with a copy of the signed ISP/MCP.

If a member declines to sign or accept a copy of the ISP/MCP, the CMO shall:

- Document in the member record the request made to the member to sign and/or accept a copy of the ISP/MCP and the reason(s) for refusal; and,
- When applicable, facilitate an arrangement by which an authorized representative, (e.g., guardian, power of attorney for health care) retains a copy of the plan to be made available to the member upon request; and,
- Inform the member of the method by which a copy of the plan can be obtained at any time thereafter from the CMO, at no cost to the member; and,
- Provide the member with the details of the plan(s) verbally upon request of the member.

The CMO shall document which method(s) (described directly above) was used to meet requirements related to member signature and plan copy in the member record.

If the refusal to sign or accept the plan(s) reflects the member's disagreement with the plan(s), the CMO shall discuss the issues with the member, and follow procedures outlined in Article IV.F., *CMO Grievance System* (page 51).

If there is documented evidence in the member record, including case notes, or when available, documentation from an outside mental health professional, that obtaining the member's signature and/or leaving a copy of the plan(s) with the member is contradictory to meeting the member's or clinical outcomes, the CMO shall:

- Document in the member record the specific reasons why the interdisciplinary team and/or outside mental health professional believe that the signature and/or copy of plan requirements should not be met.
- Review the ISP/MCP verbally with the member and/or member's authorized representative.
- Inform the member that the plan can be reviewed verbally at any time thereafter from the CMO.
- Inform the member that he/she has the right to grieve or appeal the decision to not leave a copy of the plan(s) with him/her and the CMO shall follow the procedures outlined in Article IV.F., *CMO Grievance System* (page 51).

At each subsequent plan review, the CMO shall reevaluate the decision to not obtain the member's signature or leave a copy of the plan(s) with the member. If the decision is to not obtain the member's signature and/or leave a copy of the plan(s) with the member, the procedures outlined directly above shall be followed.

9. *Providing, Arranging and Coordinating Services*

a. The interdisciplinary team is formally designated as being primarily responsible for coordinating the member's overall long-term care and health care. In accordance with the ISP/MCP, the interdisciplinary team shall authorize, provide, arrange for or coordinate services in the LTC benefit package, and coordinate all other services identified in the ISP/MCP, in a timely manner.

In addition to any standards set by the CMO, the CMO must meet and require its providers to:

i. Meet State and CMS (Centers for Medicare & Medicaid Services) waiver standards for timely access to care and member services, taking into account the urgency of need for services.

ii. Establish mechanisms to ensure compliance with State and CMS waiver standards.

iii. Monitor continuously to determine compliance with State and CMS quality standards; and take corrective action if there is failure to comply.

b. The coordination of services includes ensuring that the informal support services are involved appropriately and in accordance with the member's preferences. The CMO shall ensure coordination of services internally and with services available from community organizations and other social programs.

c. The CMO will arrange for services not covered in the benefit package, and instruct members on how to obtain these services including identification of transportation services and how they are provided by the CMO. The CMO shall at a minimum:

i. Within thirty (30) calendar days of enrollment, document the member's primary care provider, specialty care provider(s), and psychiatrist (if applicable);

ii. Contact member's primary care provider and specialty care providers(s) to provide information about services not covered in the benefit package and possible alternative payment sources including Medical Assistance available to the member;

iii. Provide information about the CMO's procedures for accessing services in the LTC benefit package;

iv. Obtain the member's informed consent to receive and share appropriate health care information between and among all service providers;

v. Provide member education in the effective use of primary care, specialty care and emergency services;

- Any procedures the provider must follow to contact the CMO before the provision of urgent or routine care;
- Procedure for creating and coordinating follow-up treatment plan;
- Policy for sharing of information and records between the CMO and emergency service provider;
- Process for arranging for appropriate hospital admissions;
- Policies regarding other continuity of care issues; and,
- Agreements, if any, between the CMO and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the CMO or emergency services provider in the absence of such an agreement.

10. *Individual Service and Member-Centered Plan Updates*
    The member and interdisciplinary team shall review and update the ISP/MCP periodically as the member's preferences, situation and condition changes, but not less than every one hundred eighty (180) calendar days, or the ISP/MCP fails to accomplish the planned outcomes.

    When the ISP/MCP update results in a termination, suspension, or reduction of a service covered under the Family Care benefit (including services authorized by a managed care organization the member was previously enrolled in or through Medicaid fee-for-service), the CMO shall discuss with the member the specific change in service and the reason(s) supporting the change in service, and follow procedures outlined in Article IV.F. (3), *Notice of Action* (page 53).

11. *Individual Service Plan and Member-Centered Plan Appeals and Grievances*
    When the ISP/MCP development or update results in denying, reducing, delaying or terminating a current service (including services authorized by a managed care organization the member was previously enrolled in or through Medicaid fee-for-service), the CMO shall discuss with the member the specific denial or change in service, and the reasons supporting the denial or change in service, and follow procedures outlined in Article IV.F., *CMO Grievance System* (page 51).

12. *Future Re-Assessments*
    After the initial comprehensive assessment described above, the CMO conducts re-assessments based on:

    a. Previous LTC Functional Screens and assessments;

    b. Changes in the member's long-term care and health care condition and situation; or,

    c. Requests for an assessment by the member, the member's representative, the member's primary medical provider, or an agency involved with the member.

13. *Interdisciplinary Team and Member Contacts*

    a. The CMO is required to conduct a face-to-face visit with a member during each quarter of the calendar year. This standard does not include the initial sixty (60) day period of assessment and care planning for new members. The CMO can establish guidelines for care management teams or create a contact standard that exceeds the minimum standard.

    b. For those members who request fewer contacts, the CMO can waive the minimum standard while the member has no current health and safety issues (e.g., has stable medical condition, the person has strong informal or community ties, and there is no physical, mental and/or emotional health risks). Under no circumstances shall

a member receive fewer than one face-to-face visit in any twelve (12) month period. The CMO shall document such requests in the member record.

c. The CMO shall provide data related to care management contacts, to the Department upon request in a format agreed to by the CMO and the Department.

14. *Member Record*
Develop and maintain a record on each member as further discussed in Article VII.B, *Member Records* (page 87).

**C. 24 Hour Coverage**

The CMO shall be responsible 24 hours each day, seven (7) days a week for providing members with access to services in the LTC benefit package; coordination of services that remain Medicaid fee-for-service (for members who are Medicaid beneficiaries); and linkages to Adult Protective Services. The CMO shall:

1. Have one phone number members or individuals acting on behalf of members can call at any time to obtain advance authorization for services in the LTC benefit package. This number must provide access to individuals with authority to authorize the services in the LTC benefit package as appropriate. Individuals at this number must also have familiarity with the CMO and the CMO's provider network.

2. Respond to such calls within thirty (30) minutes.

3. Be able to communicate with the caller in the language spoken by the caller.

4. Log these calls with time, date and any pertinent information related to person(s) involved, resolution and follow-up instructions.

5. Notify members and DHFS of any changes of this one phone number within seven business days of change.

**D. Member Safety and Risk**

The CMO shall assure member health, safety and well being and implement a policy that expressly prohibits all forms of abuse, neglect, exploitation and mistreatment of members by CMO employees and providers. The CMO's safety and risk polices must be submitted to DHFS and approved prior to the first Health and Community Supports contract between the CMO and DHFS, and be resubmitted annually thereafter. This policy shall include instruction in the proper reporting procedures when abuse or neglect is suspected.

1. *Critical Incidents/Unexpected Deaths*

a. The CMO shall gather and report specific information related to critical incidents, including unexpected deaths, locally to its Governing Board, internal committees, and the Local Long-Term Care Council.

b. In cases involving the death of a member, the date and place where the member expired, the cause of death (when known) and the relevant events preceding the death (if known) must be recorded in the member record by the CMO.

c. The CMO shall report critical incident and unexpected death aggregate data to DHFS as part of the quarterly report consistent with the Critical Incidents protocol (see Addendum VI., *Critical Incidents Protocol*, page 155.)

d. An unexpected death is any death that must be reported to the coroner or medical examiner as specified under s. 979.01 Stats., or that is reported to the Department of Regulation and Licensing or any part of the Department of Health and Family Services, or that is the result of trauma, or of which the circumstances are suspicious, obscure, or otherwise unexplained, or any death where a grievance, appeal or fair hearing is pending at the time of death. (See Article VII.B., *Member Records,* page 87).

2. *Individual Choices in Safety and Risk*

a. The CMO shall develop specific written policies that address decision-making about care as it relates to members' safety and risk. These policies shall establish standards and methods for determining acceptable risk for members, including members with a cognitive impairment or mental illness. The policies must include a member's right to freedom from unnecessary physical or chemical restraint, and specify mechanisms to balance member needs for safety, protection, good physical health and freedom from accidents, with over-all quality of life and individual choice and freedom. CMO staff and other appropriate individuals shall be informed of these policies on an ongoing basis.

b. The CMO shall have a mechanism to monitor, evaluate and improve its performance in the area of safety and risk issues. These mechanisms shall ensure there are individualized supports in place to facilitate a safe environment for each member. The CMO shall assure its performance is consistent with the understanding of the desired member outcomes and preferences. The CMO shall include family members and other informal supports when addressing safety concerns per the member's preference.

3. *Use of Isolation, Seclusion and Physical Restraints*

a. The CMO and its subcontracted providers shall comply with ch. 51.61 (1) (i) Stats and s. HFS 94.10 Wis. Adm. Code, in the use of isolation, seclusion and physical restraints, which may not be used without specific case-by-case approval of the Department, using procedures to request approval as specified by the Department.

## E. Prevention and Wellness

1. *Prevention and Wellness Plan*
   Prevention and wellness shall be part of the normal course of communications with members, and the development of the member's Individual Service Plan (ISP) and Member-Centered Plan (MCP). The CMO shall inform all members of contributions which they can make to the maintenance of their own health and the proper use of long-term care and health care services. The activities and materials used in the prevention and wellness activities shall be accessible by DHFS and the Centers for Medicare & Medicaid Services (CMS). The CMO's plan for implementing the prevention and wellness program must be submitted to DHFS and approved prior to the first Health and Community Supports contract between the CMO and DHFS. Upon contract renewal and at any time DHFS determines there has been a significant change in the CMO's capacity to offer prevention and wellness services or in the CMO's projected membership, it may require the CMO to submit documentation to demonstrate its capacity to provide prevention and wellness services.

2. *The Prevention and Wellness Program*
   The CMO's prevention and wellness program shall include the following components:

   a. *Program Coordination*
      Designated staff are responsible for the coordination and delivery of services in the program.

   b. *Practice Guidelines*
      Practice guidelines are guidelines that are developed to assist health care professionals to apply the current best evidence in making decisions about the care of individual members. The CMO shall use practice guidelines for prevention and wellness services that include member education, motivation and counseling about long-term care and health care related services. The CMO must disseminate guidelines to providers who are expected to use the guidelines and, upon request, to members.

      Practice guidelines that are condition-specific and/or disease related shall include the following elements:

      i. Overview of condition/disease;

      ii. Information related to anticipating, recognizing and responding to condition/disease related symptoms;

      iii. Information related to best practice standards for prevention and management of condition/disease;

iv. Guidelines/process for interdisciplinary team to use regarding negotiating incorporation of condition/disease prevention and management plan with member into the MCP and ISP; and,

v. Plan for quality assurance monitoring of guideline effectiveness.

c. *Measurement*
The capacity to collect, analyze and report data necessary to measure the performance of the prevention and wellness program. The reports based on this data shall be communicated to providers and members.

d. *Program Resources*
Mechanisms for facilitating appropriate use of prevention and wellness services and educating members on health promotion.

e. *Disease Prevention*
Information and policies on the prevention and management of diseases which affect the populations served by the CMO. This includes specific information for persons who have or who are at risk of developing health problems that are likely to benefit from preventive practices. Hypertension and diabetes are examples of such health problems.

f. *Independent Functioning*
Information and policies on maintaining and improving members' functional status, and the ability to perform ADLs and IADLs more independently, for the populations served by the CMO. This includes specific information for persons who have or who are at risk of impaired ability to function independently and are likely to benefit from preventive practices.

g. *Outreach Strategies*
Outreach strategies for identifying and reaching members who are least likely to receive adequate preventive services.

h. *Special Health Issues*
The dissemination of information relevant to the membership, such as nutrition, AODA prevention, reducing self mutilation behaviors, exercise, skin integrity, self care training, and coping with dementia.

i. *General Information*
The dissemination of information on how to obtain the services of the prevention and wellness program (e.g., resource center, public health department etc.), as well as additional information on, and promotion of, other available prevention services offered outside of the CMO, such as special programs on women's health.

j. *Sensitivity to Population*
Long-term care and health care related educational materials produced by the

CMO shall be appropriate for its target population(s) and reflect sensitivity to the diverse cultures served.

**F. Provision of Interpreters**

The CMO shall provide interpreter services for members as necessary to ensure availability of effective communication regarding treatment, medical history, health education and information provided to members. Interpreter services are to accommodate foreign languages and impairments (e.g., sign language) of members. (For related information, refer to Article VII.C., *Accessibility of Language*, page 90). Furthermore, the CMO shall:

1. *Availability*
   Provide for 24 hours a day, seven days a week access to interpreters conversant in languages spoken by members in the CMO. Also, upon a member or provider request for interpreter services in a specific situation where care is needed for a service in the LTC benefit package, the CMO shall make all reasonable efforts to provide an interpreter in time to assist adequately with the necessary care.

2. *Use of Professional Interpreters*
   Use professional interpreters when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate.

3. *Civil Rights of 1964*
   Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act of 1964.

**G. Adult Protective Services**

1. *Access to Adult Protective Services*
   For members in need of Adult Protective Services (APS), the CMO shall involve the entity or Department (which the County has arranged to administer APS) in the following capacities:

   a. The CMO shall invite an APS staff person to participate in the Individual Service Plan (ISP), ISP updates, comprehensive assessment and re-assessments; and,

   b. The CMO shall invite an APS staff person to participate on the interdisciplinary team to the extent that the APS staff person makes recommendations as necessary to fulfill their APS responsibilities.

2. *Protective Services Administration*
   If the County has made arrangements for the CMO to administer APS, the CMO shall assure that CMO staff with expertise in APS participate on the interdisciplinary team in the capacities noted above for those members in need of APS.

3. *Court Ordered Services*
   The CMO shall provide for court ordered treatment if it is a service in the LTC benefit package for which the CMO would be the primary payer and the member has been court ordered into placement or services through Chapter 51 or 55 of the Wisconsin Statutes.

**H. Advance Directives**

The CMO shall comply with requirements of federal and state law with respect to advance directives (e.g., living wills, durable power of attorney for health care).

The CMO shall not base the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. This provision shall not be construed as requiring the provision of care that conflicts with an advance directive.

The CMO shall:

1. Provide written information at the time of CMO enrollment to all adults receiving medical care through the CMO regarding:

   - The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and,

   - The individual's right to file a complaint with the Department of Health and Family Services, Bureau of Quality Assurance, regarding noncompliance with advance directive requirements.

2. Document in the member record whether or not the member has executed an advance directive.

3. Provide education for staff and the community on issues concerning advance directives including information and/or training about ways to recognize and minimize or eliminate any potential conflicts of interest associated with providing counseling and assistance to members in executing advanced directives.

4. Provide referral to appropriate community resources, including the resource center, for any member or individual seeking assistance in the preparation of advance directives.

5. If requested, assist the member in filing a complaint with the Bureau of Quality Assurance regarding noncompliance with advance directive requirements.

6. Have written policies regarding advance directives that includes all requirements listed in this section.

The written information must reflect changes in State law related to advance directives as soon as possible, but no later than ninety (90) days after the effective date of change.

The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider who, as a matter of conscience, cannot implement an advance directive.

## IV. Protection of Member Rights

### A. Member rights

Members have the right to all of the following:

1. Freedom from unlawful discrimination in applying for or receiving the Family Care benefit.

2. Accuracy and confidentiality of member information.

3. Prompt eligibility, entitlement and cost-sharing decisions and assistance.

4. Access to personal, program and service system information.

5. Choice to enroll in a CMO, if eligible, and to disenroll at any time.

6. Information about and access to all services of resource centers and CMOs within standards established under Family Care rules in HFS Chapter 10 Wis. Adm. Code, to the extent that the member is eligible for such services.

7. Support in understanding their rights and responsibilities related to Family Care, including due process procedures available to them as well as what options are available to express their opinions and concerns whether about resource centers, CMOs and services, including through appeals, grievances and requests for Department review and fair hearings. Resource centers, CMOs and county agencies under contract with the Department shall assist members to identify all rights to which they are entitled and, if multiple grievance, review or fair hearing mechanisms are available, which mechanism will best meet member needs.

8. Support from the CMO in all of the following:

    a. Self-identifying long-term care needs and appropriate Family Care outcomes.

    b. Securing information regarding all services and supports potentially available to the enrollee through the Family Care benefit.

    c. Actively participating in planning individualized services and making reasonable service and provider choices for achieving identified outcomes.

d. Identifying, eliminating or monitoring and managing situations where a conflict of interest may exist due to a person or entity having an interest in, or the potential to benefit from, a particular decision, outcome or expenditure.

9. Receiving services identified in the individualized service plan.

10. Support in the exercise of any rights and available grievance and appeal procedures beyond those specified elsewhere in this Article. Examples of other rights and procedures available to clients include those afforded to person who receive treatment or services for developmental disability, mental illness or substance abuse under ch. 51 Stats., and HFS 94 and those afforded to persons who reside in a nursing home, community-based residential facility, adult family home or residential care apartment complex, or who received services from a home health agency under statutes and rules for those programs.

**B. Member Rights and Responsibilities Education**

The CMO shall provide education to members on the grievance and appeal process within sixty (60) days of enrollment. Responsibility for member education may be delegated to the member's lead/primary care manager. At a minimum, this education process shall include reviewing the CMO grievance and appeal process described in the member handbook, including information about the availability of the CMO member advocate and/or member rights specialist. The CMO shall work proactively with the membership to encourage the use of the internal appeal and grievance process as the first step in the resolution of issues.

**C. Member Rights Specialist and CMO Advocacy Services**

The CMO shall provide a member rights specialist and designate a CMO employee to serve as a member advocate within the agency. The member rights specialist and CMO advocate may be the same CMO staff person.

1. *Member Rights Specialist*

   The member rights specialist shall provide support for all members in understanding their rights and responsibilities related to Family Care, including due process procedures available to them as well as what options are available to express their opinions and concerns whether about resource centers, CMOs and services, including through grievances, appeals and requests for Department review and fair hearings. The member rights specialist shall assist members to identify all rights to which they are entitled and, if multiple grievance, review or fair hearing mechanisms are available, which mechanism will best meet member needs.

2. *CMO Advocacy Services*

   a. The CMO member advocate shall report directly to top level management of the CMO, and shall perform the following functions at a minimum:

i. Assist individual members with issues and concerns that relate to the care management or the services provided through the CMO; and,

ii. Assist in assuring quality services throughout the CMO.

b. The CMO shall assure that, within two months after enrollment, members have had a face-to-face contact to make certain they are aware of the advocacy services available to them. This contact may be done by the interdisciplinary team.

**D. Authorized Representatives**

The CMO shall include the member's authorized representative (e.g., guardian, activated power of attorney for health care) in communications between the CMO and the member (e.g., member rights and responsibilities, development of Individual Service Plan), and in providing documents to the member (e.g., member handbook). The CMO shall allow the member's authorized representative to facilitate care or treatment decisions when the member is unable to do so.

**E. Informal Resolution**

Members shall obtain a prompt resolution, through established procedures, of issues raised by the member, including appeals and grievances. Members shall have the option to be represented by an advocate, peer or representative in these processes. Whenever possible the CMO shall attempt to resolve appeals and grievances informally. Attempts to resolve informally, however, do not relieve the CMO of any responsibility to comply with all requirements of the grievance process including timely resolution and prompt notice of any decisions.

**F. CMO Grievance System**

1. *Definitions*

As used in this Article the following terms have the indicated meanings:

a. *Action* means:

i. The denial or limited authorization of a requested service, including the type or level of service;

ii. The reduction, suspension, or termination of a previously authorized service that is less than requested;

iii. The denial, in whole or in part, of payment for a service;

iv. The failure to provide services and support items included in the member's ISP/MCP in a timely manner, as defined by the State;

v. The failure of a CMO to act within the timeframes of this Article for resolution of grievances or appeals; or,

vi. The development of an individualized service plan that is unacceptable to the member because any of the following apply:

- The plan is contrary to an enrollee's wishes insofar as it requires the enrollee to live in a place that is unacceptable to the enrollee.
- The plan does not provide sufficient care, treatment or support to meet the enrollee's needs and identified Family Care outcomes.
- The plan requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.

b. *Appeal* means a request for review of an action, as "action" is defined in this section.

c. *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the CMO level and the DHFS level, and access to the State fair hearing process. (Subjects for grievances include any act, decision or omission by the CMO, including but not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

2. *Grievance and Appeal System*

a. The CMO must have a grievance and appeal system in place for members that includes a CMO grievance and appeal process which provides assistance to members to access to the DHFS grievance and appeal review process as well as the State's fair hearing process.

b. Filing Requirements:

i. Authority to file.

- A member may file a grievance and a CMO level appeal and a request for DHFS review and may request a State fair hearing.
- A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file a CMO appeal.

ii. Timing. The member shall file the grievance, appeal or request for fair hearing within forty-five (45) calendar days from the date of receipt of the CMO's notice of action. Within that timeframe, any of these filings may be made separately or concurrently.

iii. Procedures.

- The member may file a grievance either orally or in writing either with DHFS or with the CMO.

- MetaStar, Inc., the Family Care external quality review organization shall act as the designated agent for DHFS. To file a grievance or appeal with DHFS, the member may contact the Family Care Grievance hotline either by writing, calling or e-mailing:

  DHFS Family Care Grievances
  c/o MetaStar
  2909 Landmark Place
  Madison, WI 53713
  Phone: (888) 203-8338 (HOTLINE)
  Fax: (608) 274-8340
  E-Mail: famcare@dhfs.state.wi.us

- The member or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

- The member may file a request for fair hearing in writing with the Division of Hearing and Appeals in the Department of Administration.

  Family Care Request for Fair Hearing
  c/o DOA Division of Hearings and Appeals
  PO Box 7875
  Madison, WI 53707-7875
  Phone: (608) 266-3096
  (608) 264-9853 (TTY)
  Fax: (608) 264-9885

3. *Notice of Action*

   a. Language and format. The notice must be in writing and must meet the language and format requirements of this contract for communications to members to assure ease of understanding.

   b. Content of notice. The notice must explain the following:

      i. The action the CMO or its contractor has taken or intends to take.

      ii. The reasons for the action.

      iii. The member's or the provider's right to file a CMO appeal.

      iv. The member's right to request DHFS review.

v. The member's right to request a State fair hearing.

vi. The procedures for exercising the rights specified in this paragraph.

vii. The member's right to appear in person before the CMO personnel assigned to resolve appeals and grievances

viii. The circumstances under which expedited resolution is available and the procedure to request it.

ix. The availability of independent advocacy services and other local organizations that might assist the member in a grievance, appeal, DHFS review or fair hearing.

x. That the member may obtain, free of charge, copies of member records relevant to the grievance, appeal, DHFS review or fair hearing and how to obtain copies.

xi. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

c. Timing of notice. The CMO must mail the notice within the following timeframes:

i. For termination, suspension, or reduction of previously authorized services, at least ten (10) calendar days prior to the date of the action.

ii. For denial of payment, at the time of any action affecting the claim.

iii. For standard service authorization decisions that deny or limit services, within the timeframe specified in Article III.A (10), *Process Direct Requests that are Determined to be not Necessary or Appropriate* (page 21).

iv. If the CMO extends the timeframe in accordance with Article III.A (6), Authorization of Services and Utilization Management (page 19) it must:

- Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and,

- Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

v. For service authorization decisions not reached within the timeframes specified for service authorizations (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

vi. For expedited service authorization decisions, within the timeframes specified in Article III.A (13), *Timeframe for Expedited Authorization Decisions* (page 22) of this contract.

4. *CMO Handling of Grievances and Appeals*

a. General requirements. In handling grievances and appeals, the CMO must meet the following requirements:

i. Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

ii. Allow members to involve anyone (e.g., significant other, professional advocate) in the grievance and appeal process.

iii. Acknowledge receipt of each grievance and appeal in writing within five business days.

iv. Ensure that the individuals who make decisions on grievances and appeals are individuals:

- Who were not involved in any previous level of review or decision-making;

- Include at least one member or one person who meets the functional eligibility for one of the target populations served by the CMO. This person must be free from conflict of interest regarding his or her participation in the governing board/committee; and,

- Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease?

  - An appeal of a denial that is based on lack of medical necessity.
  - A grievance regarding denial of expedited resolution of an appeal.
  - A grievance or appeal that involves clinical issues.

b. Special requirements for appeals. The process for appeals must:

i. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be

confirmed in writing, unless the enrollee or the provider requests expedited resolution.

ii. Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The CMO must inform the enrollee of the limited time available for this in the case of expedited resolution.)

iii. Provide the member and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

iv. Include, as parties to the appeal:

- The member and his or her representative; or,
- The legal representative of a deceased member's estate

c. The governing board of the CMO shall review and resolve appeals and grievances. This function may be delegated in writing to a grievance committee.

5. *CMO Standard Appeals and Grievance Resolution*

a. The CMO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within timeframes specified in this section.

b. Specific timeframes:

i. Standard disposition of grievances. For standard disposition of a grievance and notice to the affected parties, the timeframe is as expeditiously as the member's situation and health condition requires, but no later than 20 (twenty) business days after the CMO receives the grievance.

ii. Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, as expeditiously as the member's situation and health condition requires, but no later than 20 (twenty) business days after the CMO receives the appeal. This timeframe may be extended under paragraph (c) of this section.

iii. Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, not later than three (3) working days after the CMO receives the appeal. This timeframe may be extended under paragraph (c) of this section.

c. Extension of timeframes:

i. The CMO may extend the timeframes from paragraph (b) of this section by up to fourteen (14) calendar days if:

- The enrollee requests the extension; or,
- The CMO shows to the satisfaction of the DHFS, that there is need for additional information and how the delay is in the enrollee's interest.

ii. Requirements following extension. If the CMO extends the timeframes, it must--for any extension not requested by the member, give the member written notice of the reason for the delay.

d. Format of notice.

i. For all grievances and appeals, the CMO must provide written notice of disposition.

ii. For notice of an expedited resolution, the CMO must also make reasonable efforts to provide oral notice.

e. Content of notice of resolution. The written notice of the resolution must include the following:

i. The results of the resolution process and the date it was completed.

ii. For appeals and grievances not resolved wholly in favor of the members:

- The right to request a DHFS review or State fair hearing, and how to do so;
- The right to request to receive benefits while the review or hearing is pending, and how to make the request; and,
- That the member may be held liable for the cost of those benefits if the review or hearing decision upholds the CMO's action.

6. *CMO Expedited Resolution of Appeals*

a. The CMO must establish and maintain an expedited review process for appeals, when the CMO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

b. Punitive action. The CMO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.

c. Action following denial of a request for expedited resolution. If the CMO denies a request for expedited resolution of an appeal, it must:

i. Transfer the appeal to the timeframe for standard resolution in accordance with subsection 5, above; and,

ii. Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

## G. Department Appeal and Grievance Resolution Process

MetaStar, Inc., the Family Care external quality review organization shall act as the designated agent for the following requirements.

1. *General Review Process*
   The Department shall complete a timely review, investigation and analysis of the facts surrounding member appeals or grievances in an attempt to resolve concerns and problems informally, whenever a member or a member's authorized representative:

   a. Makes an appeal or grievance directly to the Department; or,

   b. Requests Department review of a decision arrived at through a county agency, resource center or care management organization grievance process.

2. *Timeliness of Review*
   The department shall complete its review under sub. 1 above within twenty (20) business days of receiving a request for review from a member, unless the member and the Department agree to an extension for a specified period of time.

3. *Concurrent Review Process*
   Whenever the department receives notice from the Department of Administration's Division of Hearings and Appeals that it has received a fair hearing request, the department shall use the process in sub. 1 above to conduct a concurrent review in accordance with s. HFS 10.55 (4) Wis. Adm. Code.

   The CMO shall provide the Department or the Department's delegate (currently MetaStar), with all requested documentation to support the DHFS or concurrent review process within five (5) business days of the entity making the request.

## H. Fair Hearing Process

1. *Request for Fair Hearing*
   A member, immediate family member, or someone with legal authority to act on the member's behalf (as specified in ch. HA (Hearing and Appeals) 3.05 (2) Wis. Adm.

Code) can file a request for a fair hearing process for the following types of incidences before, during or after using the CMO grievance process:

a. Failure to provide timely services and items that are included in the individual service plan;

b. Reduction of services or items in the LTC benefit package;

c. The Individual Service Plan (ISP) is unacceptable to the member because the ISP requires the member to live in place that is unacceptable to the member;
d. The services or items identified in the ISP are insufficient to meet the member's needs, or are unnecessarily restrictive or unwanted by the member;

e. Involuntary disenrollment;

f. The CMO makes a decision on an appeal or grievance that is entirely or partially adverse to the member; or,

g. The member disagrees with the conclusion following a Department investigation of a Department appeal or grievance.

2. *When to File*
The member must file the request for a fair hearing within forty-five (45) calendar days of one the types of incidences noted above, or receipt of written notice from the CMO or DHFS (whichever is later).

3. *Timelines*
The Wisconsin Department of Administration, Division of Hearings and Appeals (DHA) is required to make a decision will be made through the fair hearing process as expeditiously as the member's situation or health condition requires or within ninety (90) calendar days of the date the member filed a request for the hearing. The decision will be reached within three days of receipt of the hearing request if the standard resolution timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function and,

a. The appeal was first heard by the CMO.

b. The CMO was subject to the expedited appeal process but did not resolve within the expedited timeframe.

c. The appeal involved a denial of service.

d. The CMO decision was wholly or partially adverse to the member using CMO expedited appeal timeframes.

Any formal decision made through the fair hearing process under this section, shall be subject to member grievance rights as provided by State and Federal laws and rules.

The fair hearing process will include receiving input from the member and the CMO in considering the grievance.

4. *Access to Services*
   If the CMO's grievance or appeal resolution decision to deny a service is reversed through the fair hearing process, the CMO shall authorize or provide the service as expeditiously as the member's situation or health condition requires, but no later than thirty (30) calendar days after the receipt of the reversal.

5. *Parties to the Appeal*
   The parties to the appeal include:

   a. The member and his or her representative; or,

   b. The legal representative of a deceased member's estate; and,

   c. The representatives of the CMO.

## I. Continuation and Duration of Benefits

1. *When Services will Continue*
   The CMO shall continue the member's current benefits until the issuance of an appeal or grievance decision under the following circumstances:

   a. The member files a grievance by the date of the intended action, or within fourteen (14) calendar days of receipt of the written notice from the CMO and/or DHFS (whichever is later); and,

   b. The current level of services was authorized by the CMO interdisciplinary team; and,

   c. The member requests the continuation.

2. *Duration*
   If benefits are continued or reinstated, pending the issuance of an appeal or grievance decision, they must be continued until one of the following occurs:

   a. The enrollee withdraws the appeal or grievance.

   b. The enrollee does not request a State fair hearing within ten (10) calendar days from when the CMO mails an adverse CMO decision.

   c. A State fair hearing decision, adverse to the enrollee is made.

   d. The authorization expires or authorization service limits are met.

3. *Reasonable Alternatives*
   If the requested services were not authorized by the CMO interdisciplinary team, the CMO shall provide reasonable alternatives to the requested services, as appropriate, until the issuance of the grievance decision.

## J. Effectuation of Grievance and Appeal Resolutions

1. *Services Not Furnished While the Appeal is Pending*
   If the CMO or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CMO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than the earlier of:

   a. The date indicated for effectuation by the fair hearing officer; or,

   b. Thirty (30) calendar days from the receipt of the decision.

2. *Services Furnished While the Appeal is Pending*
   If the CMO, or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CMO must pay for those services.

## K. Documentation and Reporting

1. *Notice of Decision to DHFS*
   If the CMO makes a decision on an appeal or grievance that is entirely or partially adverse to the member, the CMO shall submit the decision and all supporting documentation to DHFS as expeditiously as the member's situation and health condition requires, but no later than 20 (twenty) days after the member receives notification of the decision from the standard grievance resolution process.

2. *CMO Records Retention*
   The CMO shall retain the documents related to each appeal and grievance for three years in a central location and make them accessible to DHFS. If any action involving the documents or log is started before the expiration of the three year period (e.g., litigation, audit), the CMO shall retain the records until completion of the action and resolution of issues which arise from it or until the end of the regular three year period (whichever is later).

3. *Quarterly Reports*
   Along with the Quarterly Report (as specified in Article X.B. (3), page 109) the CMO shall submit to DHFS an appeal and grievance report consisting of a summary and a log, as follows:

   a. *Summary*
      The summary shall be an analysis of the trends the CMO has experienced regarding types of issues appealed and grieved through the local CMO process,

the DHFS process and the State fair hearing process. In addition, the summary should identify whether specific providers are the subject of appeals or grievances. If the summary reveals undesirable trends, the CMO shall conduct an in-depth review, report the results to DHFS, and take appropriate corrective action.

b. *Log*
The log shall include the following information about each appeal and grievance received through the local process:

i. Whether it is an appeal or a grievance;

ii. The nature of the appeal or grievance;

iii. The date of receipt of the appeal or grievance;

iv. The date the receipt was acknowledged by the CMO;

v. The date on which the appeal or grievance was resolved through mediation or the date a decision was issued by the local appeal and grievance committee;

vi. A summary of the decision;

vii. Whether the member's request was upheld by a local committee decision, whether the member's request was partially upheld or whether the committee agreed with the CMO decision or response to a grievance; and,

viii. Whether a disenrollment occurred during the course of the appeal or grievance or following receipt of a committee decision, and if so, the reason for the disenrollment.

The documentation and reporting required in this Article regarding appeals and grievances provide the basis for monitoring by the CMO and DHFS. DHFS shall review the information as part of the State quality strategy. The information required above will be submitted by direct entry into a web-based application on the MetaStar secured website when it is made available, and at a time mutually agreed upon by CMO and DHFS.

4. *Treatment of Records*
The requirements of this section shall be in compliance with Article VI.B., *Member Input* (page 83), and Article XIII., *Confidentiality of Records* (page 115).

**L. Information to Providers**
At the time of subcontracting, the CMO shall furnish providers with information regarding the appeal and grievance processes as specified in this Article.

## V. CMO Functions: Service Providers

### A. Choice of Providers and Interdisciplinary Teams

1. *Information to Members*
   The CMO shall inform members about the full range of provider choice available to them, including free choice of medical and other providers that remain fee-for-service.

2. *Member Choice of Providers*
   For services in the LTC benefit package that involve providing intimate personal needs or when a provider frequently comes into the member's home, the CMO shall, upon request of the member, purchase services from any qualified provider who will accept and meet the provisions of the CMO's subcontract for subcontractors of the same service. These services include, but are not limited to, personal care, home health, private duty nursing, supportive home care and chore service. The provisions of subcontracts for services mentioned in this paragraph shall focus on quality and cost effectiveness, and not be constructed in such a way so as to limit the network of providers.

   The State must ensure, through its contracts, that each CMO consistent with the scope of the CMO's contracted services, provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

3. *Non-CMO Providers*
   The CMO shall maintain a process to consider a member's request for a non-CMO provider, which is a provider who does not have an agreement with the CMO for providing services in the LTC benefit package to members. The CMO shall arrange for services with non-CMO providers if the member's request is authorized by the CMO. Instances where the member's request for a non-CMO provider is warranted include:

   a. When the CMO does not have the capacity to meet the need;

   b. When the CMO does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers;

   c. When the CMO can not meet the need on a timely basis; or,

   d. When transportation or physical access to the CMO providers causes an undue hardship to the member.

4. *Member Choice of Interdisciplinary Teams*
   The CMO shall allow a member to change interdisciplinary teams up to two times per calendar year if the CMO has additional interdisciplinary teams to offer the member.

5. *Provider Access Standards*
   The CMO shall ensure all services and all service providers comply with access standards provided in Article III.B. (9), *Providing, Arranging and Coordinating Services* (page 40).

**B. Provider Network and Subcontracts**

The term "subcontract" in this section refers to the definition provided in Addendum I., *Definitions* (page 120). The term does not apply to supplemental contracts between the CMO and DHFS. DHFS shall have sole authority to determine the conditions and terms of supplemental contracts between the CMO and DHFS.

The CMO may not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.

If the CMO declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.

The CMO provider network selection must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

1. *Cost Control Measures*
   In establishing provider and management subcontracts, the CMO shall seek to maximize the use of available resources and control costs. Cost control measures can include:

   a. Using different reimbursement amounts for different specialties.

   b. Using different reimbursement amounts for different practitioners in the same specialty.

   c. Establishing measures that are designed to maintain quality of service consistent with the CMO responsibilities to serve members.

2. *Subcontractor Audits*
   CMO providers may be eligible for waivers of the audit requirements under s. 46.036 (4) Stats., subject to approval by DHFS.

3. *Department's Discretion*
   DHFS may approve, approve with modification, or deny subcontracts under this contract at its sole discretion. DHFS may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. DHFS may consider such factors as it deems appropriate to protect the interests of the State and members, including but not limited to, the proposed subcontractor's past performance.

4. *Legal Liability*
   The CMO shall assure that all subcontracts shall not terminate legal liability of the CMO under this contract. The CMO may subcontract for any or all functions covered by this contract, subject to the requirements of this contract.

5. *Deadlines*
   If DHFS requires the CMO to find a new subcontractor, the CMO shall secure a new subcontractor in one hundred-twenty (120) calendar days, and sixty (60) calendar days to implement any other change required by DHFS. DHFS will acknowledge the approval or disapproval of a subcontract within fourteen (14) calendar days after its receipt from the CMO. Lack of such acknowledgment within fourteen (14) calendar days shall constitute approval.

6. *Member Provider Communications*
   The CMO may not prohibit or otherwise restrict a provider from advising members about the long-term care and health care status of the member, or medical care and treatment for the member's condition or disease regardless of whether the service are services in or outside of the LTC benefit package if the provider is acting under the lawful scope of practice.

7. *Evidence of Service Capacity Before Effective Date of Contract*
   By the effective date of this contract, the CMO shall have submitted its subcontracts or revisions to subcontracts previously approved, and obtained Department approval by one of two means: 1) the CMO submits each subcontract to DHFS for review and approval or disapproval, or 2) the CMO submits template language to DHFS planned for use in the CMO's subcontracts for Department review and approval or disapproval. After the CMO receives approval on templates, the CMO sends DHFS a certification stating the approved templates were used for each subcontractor. For each subcontractor the certification includes the subcontractor's name, service type and date of subcontract expiration. Any disapproval of subcontracts may result in the application by DHFS of remedies pursuant to Article VIII.K., *Remedies for Violation, Breach, or Non-Performance of Contract* (page 100).

   By the effective date of this contract, the CMO shall demonstrate to DHFS an adequate capacity to provide the projected membership in the service area with: the appropriate range of services; access to prevention and wellness services; a sufficient number, mix and geographic distribution of providers of services; specialized expertise with the target population(s) served by the CMO; culturally competent providers (see Article V.F., *Cultural Competency*, page 79); and services that are physically accessible and available on a timely basis. Any CMO that will, at any time during the term of this contract, operate the CMO in a service area where the Family Care benefit has been available for at least 24 months, shall demonstrate capacity to provide services to all entitled persons who seek enrollment in the CMO. The CMO is not required to contract with providers beyond the number necessary to meet the needs of members.

The CMO shall develop standards for geographic access and timeliness of access to services in the LTC benefit package and member services that meet or exceed such standards as may be established by CMS or DHFS.

Evidence of adequate capacity to serve the membership is as follows:

a. For all services in the LTC benefit package evidence of adequate capacity to serve the membership is by subcontractual relationships with providers or ability to provide the service directly.

b. For residential care facilities evidence of adequate capacity shall include identification of the availability of residential providers offering private rooms, and a process for moving an individual to a private room when one becomes available that is consistent with the member's preferences.

8. *Evidence of Service Capacity After Effective Date of Contract*
DHFS may review any and all subcontracts at any time.

a. *Certification of Subcontracts*
A certification of subcontracts shall be submitted and receive Department approval before renewing this contract, and at any time DHFS determines there has been a significant change in the CMO's capacity to offer services in the LTC benefit package or in the CMO's projected membership. The certification shall include:

i. A statement that all of the required provisions of subcontracts are met (see subsection 9., *Requirements for Subcontracts*, below);

ii. A listing of the provider network (which consists of provider/agency name, location, services furnished by provider, and whether the provider is accepting new CMO members or not); and,

iii. Expiration date of all subcontracts.

b. *Notices About Provider Changes*
The CMO is required to notify DHFS of anticipated and unexpected changes in the network of providers that have potential to limit member access or compromise the CMO's ability to authorize necessary services. Notices about significant changes in providers that are to be sent to members and shared with the resource center must be submitted to DHFS prior to delivery. The CMO shall provide each member affected by the change, written notice of the change at least thirty (30) days before the effective date of the change.

c. *Information to Members*
Upon the request of members, the CMO shall make available information about the identity, locations, qualifications, and availability of services in the LTC benefit package from providers that participate in the CMO.

d. *Timeliness and Quality of Services*
The CMO shall furnish services in the LTC benefit package promptly and without compromising quality of care.

e. *Monitoring Access to Services*
The CMO shall continuously monitor the extent to which it maintains an adequate capacity to provide the membership with the appropriate range of services, access to prevention and wellness services, a sufficient number, mix and geographic distribution of subcontractors of services, specialized expertise with the target population(s) served by the CMO, culturally competent providers, (see Article V.F., *Cultural Competency*, page 79), and accessible services (meaning physically accessible, and available on a timely basis). The CMO shall take corrective action on deficiencies in any of these areas as necessary.

9. *Requirements for Subcontracts*
All subcontracts for member services shall be in writing, shall include the provisions of this subsection, and shall include any general requirements of this contract that are appropriate to the service. The subcontractor must agree to abide by all applicable provisions of this contract. Subcontractor compliance with this contract specifically includes, but is not limited to, the following requirements (except for specific areas that are inapplicable in a specific subcontract):

a. *Parties of the Subcontract*
The CMO and subcontractor entering into the agreement are clearly defined.

b. *Definitions*
Subcontract defines the terms that may be interpreted in ways other than what the CMO intends.

c. *Services*
Subcontract clearly delineates the services being provided, arranged, or coordinated by the subcontractor.

d. *Compensation*
Subcontract specifies rates for purchasing services from the provider. Subcontract specifies payment arrangements in accordance with Article V.C. (3), *Thirty-Day Payment Requirement* (page 74).

e. *Term and Termination*
Subcontract specifies the start and end date of the subcontract and the means to renew, terminate and renegotiate. Subcontract specifies the CMO's ability to

terminate and suspend the subcontract based on quality deficiencies and a process for the provider appealing the termination or suspension decision.

f. *Legal Liability*
Subcontract agrees that no terms of the subcontract are valid which terminate legal liability of the CMO in accordance with Article VII.F., *Compliance with Applicable Law* (page 94).

g. *QA/QI Programs*
Subcontractor agrees to participate in and contribute required data to the CMO's QA/QI programs as required in Article VI., *CMO Functions: Quality Assurance/Quality Improvement* (page 79).

h. *Utilization Data*
Subcontractor agrees to submit CMO utilization data in the format specified by the CMO, so the CMO can meet DHFS specifications required by Article X., *Reports and Data* (page 106), and Addendum IV., *Reporting* (page 139).

i. *Non-Discrimination*
Subcontractor agrees to comply with all non-discrimination requirements in Article VII.D., *Affirmative Action and Civil Rights* (page 90.)

j. *Insurance and Indemnification*
Subcontractor attests to carrying the appropriate insurance and indemnification.

k. *Independent Contractor*
Subcontract recognizes the agreement is between two separate parties that are independently and freely entering into a subcontract.

l. *Notices*
Subcontract specifies a means and a contact person for each party for purposes related to the subcontract (e.g., interpretations, subcontract termination).

m. *Access to Premises*
Subcontractor agrees to provide representatives of the CMO, as well as duly authorized agents or representatives of DHFS and the Federal Department of Health and Human Services, access to its premises, and/or medical records in accordance with Article VII.I., *Access to Premises and Information* (page 96).

n. *Certification and Licensure*
CMO subcontractors and health care facilities agree to provide licensure, certification and accreditation status upon request of the CMO. Health professions which are certified by Medicaid (e.g., physical therapy) agree to provide information about their education, Board certification and recertification upon request of the CMO. Subcontractor agrees to notify the CMO of changes in licensure.

o. *Records*
Subcontractor agrees to comply with all applicable Federal and State record retention requirements.

p. *Member Records*
Subcontractor agrees to the requirements for maintenance and transfer of records stipulated in Article VII.B., *Member Records* (page 87). Subcontractor agrees to make records available to members and his/her authorized representatives within ten (10) business days of the record request.

Subcontractors must forward records to the CMO pursuant to grievances within fifteen (15) business days of the CMO's request. If the subcontractor does not meet the fifteen (15) business day requirement, the subcontractor must explain why and indicate when the records will be provided.

Subcontractor agrees otherwise to preserve the full confidentiality of records in accordance with Article XIII., *Confidentiality of Records* (page 115).

q. *OSHA Requirement*
Subcontractor attests to meeting applicable OSHA requirements.

r. *Access to Services*
Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services necessary to achieve outcomes that are in the LTC benefit package (e.g., Third Party Liability recovery procedures that delay or prevent care).

s. *Authorization for Providing Services*
Subcontract delineates the process the provider follows to receive authorization for providing services in the LTC benefit package to members. Subcontractor agrees to clearly specify authorization requirements to its providers and in any sub-subcontracts.

t. *Billing*
Subcontractor agrees not to bill a member for services in the LTC benefit package that received advance authorization from the CMO and were provided during the member's period of CMO enrollment. This provision shall continue to be in effect even if the CMO becomes insolvent.

u. *Appeals*
Subcontractor agrees to abide by the terms of Article V.C. (5), *Appeals to the CMO and Department for Payment/Denial of Providers Claims* (page 75).

v. *Appeals and Grievances*
Subcontractor agrees to comply with the CMO's efforts regarding member's appeals and grievances that may involve the subcontractor.

w. *Prohibited Practice*
The CMO and subcontractor agree to prohibit communication, activities or written materials that make any assertion or statement, that the CMO or provider is endorsed by CMS, the Federal or State government, or any other entity.

10. *In Establishing and Maintaining Subcontracts, the CMO Must:*

a. Establish mechanisms to ensure compliance by providers.

b. Monitor providers regularly to determine compliance.

c. Take corrective action if there is a failure to comply.

11. *Additional Requirements for Management Subcontracts*
Management subcontracts for administrative services will be subject to additional review to assure that rates are reasonable:

a. *Services and Compensation*
Subcontracts for CMO administrative services must clearly describe the services to be provided and the compensation to be paid.

b. *Bonuses, Profit-Sharing*
Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to the CMO, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the subcontract period.

c. *Reasonableness*
Any such bonus or profit-sharing shall be reasonable compared to services performed. The CMO shall document reasonableness.

d. *Limits*
A maximum dollar amount for such bonus or profit-sharing shall be specified for the subcontract period.

12. *Ownership*
The CMO agrees to submit to DHFS within thirty (30) calendar days of the effective date of the contract, full and complete information as to the identity of each person or corporation with an ownership or control interest in the CMO, or any subcontractor in which the CMO has a 5 percent or more ownership interest.

a. *Definition of "Person with an Ownership or Control Interest"*
A "person with an ownership or control interest" means a person or corporation that:

i. Owns, directly or indirectly, 5 percent or more of the CMO's capital or stock or receives 5 percent or more of its profits. The percentage of direct

ownership or control is calculated by multiplying the percent of interest that a person owns by the percent of the CMO's assets used to secure the obligation. Thus, if a person owns 10 percent of a note secured by 60 percent of the CMO's assets, the person owns 6 percent of the CMO. The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the CMO, the person owns 8 percent of the CMO;

ii. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the CMO or by its property or assets, and that interest is equal to or exceeds 5 percent of the total property and assets of the CMO; or,

iii. Is an officer or director of the CMO (if it is organized as a corporation) or is a partner in the CMO (if it is organized as a partnership).

b. *Information to be Disclosed*
The following information must be disclosed:

i. The name and address of each person with an ownership or controlling interest of 5 percent or more in the CMO or in any subcontractor in which the CMO has direct or indirect ownership of 5 percent or more;

ii. A statement as to whether any of the persons with ownership or control interest are related to any other of the persons with ownership or control interest as spouse, parent, child, or sibling; and,

iii. The name of any other organization in which the person also has ownership or control interest. This is required to the extent that the CMO can obtain this information by requesting it in writing. The CMO shall keep copies of all of these requests and responses to them, make them available upon request, and advise DHFS when there is no response to a request.

c. *Potential Sources of Disclosure Information*
This information may already have been reported on Form HCFA-855, "Disclosure of Ownership and Control Interest Statement." Form HCFA-855 is likely to have been completed in two different cases. First, if the CMO is federally qualified and has a Medicare contract, it is required to file Form HCFA-855 with CMS within 120 calendar days of the CMO's fiscal year end. Secondly, if the CMO is owned by or has subcontracts with Medicaid providers that are reviewed by the State survey agency, these providers may have completed Form HCFA-855 as part of the survey process. If Form HCFA-855 has not been completed, the CMO may supply the ownership and control information on a separate report or submit reports filed with the State's insurance or health regulators as long as these reports provide the necessary information for the prior 12-month period.

As directed by the CMS Regional Office (RO), this Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to DHFS and the RO prior to each contract period. If the CMO has not supplied the information that must be disclosed, a contract with the CMO is not considered approvable for this period of time and no full Federal participation is available for the period of time preceding the disclosure.

d. *Prohibited Providers*
The CMO may not knowingly have a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities as a director, officer, partners, or person with a beneficial ownership of more than 5% of the entity's equity, or have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the CMO's obligations under this contract.

13. *Business Transactions*
The CMO shall disclose to DHFS information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903 (m) (2) (A) (viii) and 1903 (m) (4) of the Act) Definition of a Party in Interest. As defined in Section 1318 (b) of the Public Health Service Act, a party in interest is:

a. Any director, officer, partner, or employee responsible for management or administration of a CMO; any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the CMO; any person who is the beneficial owner of more than 5 percent of the CMO; or, in the case of a CMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law; or,

b. Any organization in which a person described in subsection (a) is director, officer or partner; has directly or indirectly a beneficial interest of more than 5 percent of the equity of the CMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of the CMO;

c. Any person directly or indirectly controlling, controlled by, or under common control with the CMO; or,

d. Any spouse, child, or parent of an individual described directly above in a., b. or c.

14. *Types of Transactions Which Must be Disclosed*
Business transactions which must be disclosed include:

a. Any sale, exchange or lease of any property between the CMO and a party in interest;

b. Any lending of money or other extension of credit between the CMO and a party in interest; and,

c. Any furnishing for consideration of goods, services (including management services) or facilities between the CMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of his/her employment.

The information which must be disclosed in the transactions listed directly above between the CMO and a party in interest includes:

i. The name of the party in interest for each transaction;

ii. A description of each transaction and the quantity or units involved;

iii. The accrued dollar value of each transaction during the fiscal year; and,

iv. Justification of the reasonableness of each transaction.

If this contract is being renewed or extended, the CMO shall disclose information on these business transactions which occurred during the prior contract period. If the contract is an original contract with DHFS, but the CMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of these CMO business transactions must be reported.

The CMO shall notify DHFS within seven calendar days of any notice given by the CMO to a subcontractor, or any notice given to the CMO from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce member access to care.

If DHFS determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then DHFS may invoke the remedies provided for in Article VIII.K., *Remedies for Violation, Breach, or Non-Performance of Contract* (page 100). These remedies include contract termination (with notice to the CMO and an opportunity to correct provided for), and suspension of new enrollment.

A CMO may enter into an MOU with a business, provider or similar entity. Such an MOU may not violate any of the requirements found in this contract concerning contracts or subcontracts between the CMO and a business, provider or similar entity.

The CMO shall submit MOUs referred to in this contract to DHFS upon DHFS's request.

The CMO shall submit copies of changes in MOUs to DHFS within fifteen (15) calendar days of the effective date of the contract.

## C. Payment to Providers

1. *Allowable Cost Policy Not Applicable*
   In subcontracting with and paying providers, the CMO is not subject to ss. 46.036 (3) and (5m) Stats., which refer to allowable costs. The CMO may expend funds from the per member per month payment rates on a subcapitated basis.

2. *Medicaid Rates*
   The CMO shall not pay itself nor its providers more than the Medicaid fee-for-service rates for Medicaid covered services in the LTC benefit package unless DHFS approves a higher level of payment. DHFS will base the approval on whether the service will result in added quality or value, or if the availability of service providers at the Medicaid fee-for-service rate is not sufficient.

   Prior to the effective date of this contract, the CMO shall submit a request to DHFS to pay itself a care management rate or any other service provided by the CMO for Medicaid covered services more than the Medicaid fee-for-service rate. The CMO is required to identify the methodology by which the rate was created and documentation to support the rate calculation.

   Prior to the effective date of any subcontractor contract, the CMO shall submit a request to DHFS to pay the provider for Medicaid covered services more than the Medicaid fee-for-service rate.

   Rate changes, resulting in any additional increase in payment are also subject to Department approval according to the requirements described above.

3. *Thirty Day Payment Requirement*
   The CMO shall pay at least 90 percent of clean claims from subcontractors for services in the LTC benefit package that receive advance authorization from the CMO within thirty (30) calendar days of receipt of bill, and 99 percent within ninety (90) calendar days, except to the extent subcontractors have agreed to later payment. The CMO agrees not to delay payment to subcontractors pending subcontractor collection of third party liability (TPL) unless the CMO has an agreement with their subcontractor to collect TPL.

4. *Claims Retrieval System*
   The CMO shall maintain a claims retrieval system that can, on request, identify date service was received, action taken on all provider claims (e.g., paid, denied, other), and when action was taken. The CMO shall date stamp all provider claims upon receipt.

5. *Appeals to the CMO and Department for Payment/Denial of Providers Claims*
The CMO shall:

   a. Provide the name of the person and/or function at the CMO to whom provider appeals should be submitted.

   b. Provide written notification to providers of the CMO payment/denial determinations. These notifications will include:

      i. A specific explanation of the payment amount or a specific reason for the payment denial;

      ii. A statement regarding the provider's rights and responsibilities in appealing the CMO's initial determination by submitting a separate letter or form which:

         - Is clearly marked "appeal";

         - Contains the provider's name, date of service, date of billing, date of rejection, and reason(s) claim merits reconsideration for each appeal; and,

         - Is submitted to the person and/or function at the CMO that handles Provider Appeals within sixty (60) calendar days of the initial denial or partial payment.

      iii. A statement advising the provider of the provider's right to appeal to DHFS if the CMO fails to respond to the appeal (as indicated directly above) within forty-five (45) calendar days, or if the provider is not satisfied with the CMO's response to the request for reconsideration. All appeals to DHFS must be submitted in writing within sixty (60) calendar days of the CMO's final decision to DHFS as follows:

         **CMO Contract Administrator**
         **Bureau of Long-Term Support**
         **1 West Wilson Street, Room 518**
         **PO Box 7851**
         **Madison, WI 53707-7851**

   c. Accept written appeals from providers who disagree with the CMO's payment/denial determination, if the provider submits the dispute in writing within sixty (60) calendar days of the initial payment/denial notice. The CMO has forty-five (45) calendar days from the date of receipt of the request for reconsideration to respond in writing to the provider. If the CMO fails to respond within that time frame, or if the provider is not satisfied with the CMO's response, the provider may seek a final determination from DHFS.

d. Accept DHFS's determinations regarding appeals of disputed claims. In cases where there is a dispute about the CMO's payment/denial determination and the provider has requested a reconsideration by the CMO according to the terms described above, DHFS will hear appeals and make final determinations. These determinations may include the override of the CMO's time limit for submission of claims in exceptional cases. DHFS will not exercise its authority in this regard unreasonably. DHFS will accept written comments from all parties to the dispute prior to making the decision. Appeals must be submitted to DHFS within sixty (60) calendar days of the date of written notification of the CMO's final decision resulting from a request for reconsideration. DHFS has forty-five (45) calendar days from the date of receipt of all written comments to respond to these appeals. The CMO shall pay provider(s) within forty-five (45) calendar days of receipt of DHFS's final determination.

e. Provider Appeal Log. Along with the Quarterly Report (as specified in Article X. B. (3), page 109) the CMO shall submit to DHFS a provider appeal log as follows:

i. Name of the provider;

ii. Type of service;

iii. Date of service;

iv. Amount of the claim;

v. Date of receipt of the appeal;

vi. Appeal decision by the CMO; and,

vii. Reason for the decision;

## D. Employment Practices

1. *Competency Standards*
The CMO shall set competency standards for CMO staff providing services in the LTC benefit package. The CMO shall provide or arrange for training for such CMO employees to meet competencies. The CMO shall establish a system for monitoring CMO staff providing services in the LTC benefit package to assure for the provision of quality services. Refer to Article VI.C., *Provider Selection and Retention* (page 84) for related employee standards.

2. *Family Members*
A person in the member's family (except for the spouse of a member) shall be paid by the CMO for services if all of the following apply:

a. The service is authorized by the interdisciplinary team.

b. The member's preference is for the family member to provide the service.

c. The interdisciplinary team shall monitor and manage any conflict of interest situation that may occur as a result of the family member providing services.

d. The family member meets the CMO's standards for its subcontractors or employees providing the same service.

e. The family member will either:

i. Provide an amount of service that exceeds normal family care giving responsibilities for a person in a similar family relationship who does not have a disability; or,

ii. Find it necessary to forego paid employment in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

3. *Intimate Care Services*
If the CMO is the employer of attendants for the purposes of supportive home care, personal care or home health aid services the following conditions shall be met:

a. Members are offered the opportunity to participate with the CMO in choice and assignment of attendant(s) that provide the service;

b. Members are involved with training the CMO attendant(s) (if desired by the member);

c. Members are involved in negotiating hours (e.g., time of day) of services;

d. Members regularly participate in the evaluation of services provided by their CMO attendant(s); and,

e. Members are involved in the supervision of CMO attendant(s) along with the CMO attendant supervisor (if desired by the member, and to the extent of his/her abilities).

4. *Member Employs Attendants*
The member shall have the opportunity to directly be the employer of attendants for supportive home care services as specified in HFS 73.06 and 73.08 Wis. Adm. Code.

5. *Federal Department of Labor*
The CMO shall implement and adhere to rules and regulations prescribed by the United States Department of Labor and in accordance with 41 CFR60.

6. *Criminal Background Checks*
   The CMO shall comply with regulations of the United States Department of Labor recited in 20 CFR, 741 and the Federal Rehabilitation Act of 1973. The CMO shall ensure compliance by any and all subcontractors engaged by the CMO under this contract with said regulations.

   The CMO is an entity certified by the state and shall comply with HFS 12 Wis. Adm. Code, related to criminal background and other checks.

   All requirements of HFS 12 pertain to any providers or CMO staff who comes into direct contact with a member, including:

   a. The CMO shall establish and implement a policy consistent with HFS 12 Wis. Adm. Code, to appropriately respond when there is a criminal conviction related for a person who is to be paid to provide services to a member;

   b. The CMO shall perform, or require providers to perform, criminal background checks on people paid to provide services to a member in accordance with HFS 12 Wis. Adm. Code;

   c. For CMO provider organizations that have staff providing services that result in direct contact with CMO members, the CMO shall ensure criminal background checks are completed in accordance with HFS 12 Wis. Adm. Code;

   d. The CMO maintains the ability to not pay any provider if the CMO deems it is unsafe based on the findings of past criminal convictions stated in the criminal background check; and,

   e. The criminal background check shall be made available to the member or entity that is the employer.

## E. Provider Certification

1. *Provider Standards*
   The CMO shall use only providers that:

   a. Meet the provider standards in Wisconsin's Family Care home and community-based waivers and are consistent with any applicable DHFS policies and procedures, including the use of certified RCACs and certified adult day care; or,

   b. Are certified by the Medicaid program for those services in the LTC benefit package that would have been provided under Medicaid fee-for-service; or,

   c. Meet the CMO's provider standards, which are approved by the State.

2. *Information to Members*
   The following information shall be furnished by the CMO upon the request of a member:

   a. The licensure, certification and accreditation status of the managed care organizations and providers in the CMO's provider network; and,

   b. The education, board certification and recertification of health professions which are certified by Medicaid (e.g., physical therapy).

### F. Cultural Competency

1. *Cultural Values*
   The CMO shall incorporate in its policies; administration, provider contract, and service practice the values of honoring members' beliefs, being sensitive to cultural diversity, and fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds. The CMO shall have specific policy statements on these topics and communicate them to subcontractors.

2. *Cultural Competency*
   The CMO shall encourage and foster cultural competency among CMO staff and providers.

3. *Cultural Preference*
   The CMO shall permit members to choose providers from among the CMO's network based on cultural preference.

4. *Appeals and Grievances*
   The CMO shall accept appeals and grievances from members related to a lack of access to culturally appropriate care. Culturally appropriate care is care delivered with sensitivity, understanding, and respect for the member's culture.

### G. Reproduction and Distribution of Materials

The CMO shall, at the CMO expense, reproduce and distribute information or documents sent to the CMO from DHFS that contain information providers must have in order to fully implement this contract. These materials shall be distributed within a reasonable time frame stipulated by DHFS.

## VI. CMO Functions: Quality Assurance/Quality Improvement (QA/QI)

### A. QA/QI Plan, Program, and Coordination

1. *QA/QI Plan*
   The CMO's governing board or its designee shall set new goals and objectives annually based on findings from quality assurance and improvement activities. The CMO's governing board or its designee shall subsequently approve a written QA/QI

work plan that outlines the scope of activity and the goals, objectives, and timelines for the QA/QI program for the contract period. The CMO shall submit a copy of the plan and governing board approval prior to the effective date of this contract (as specified in Addendum IX., *CMO Certification and Re-Contracting*, page 166).

2. *QA/QI Program*
   The CMO QA/QI program shall include the following basic activities: (1) conduct performance improvement projects, (2) processes to monitor and detect underutilization and over utilization of services, and (3) processes to monitor and assess the quality and appropriateness of care furnished to Family Care members. In addition, the CMO shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the CMO's QA/QI program. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of eligibility for financial reasons.

   The CMO shall implement a QA program to assure that the quality of care and services it provides either through CMO staff or sub-contracted providers is maintained at acceptable levels. The scope of activities to assure quality must include: potential problem identification through screening; verifying quality-related problems and causes; evaluation of problems to determine severity and whether or not further study is warranted by audit or other means; designing activities to address deficiencies; recommending corrective action plans; assuring the implementation of corrective action plans; and conducting follow-up activities to determine whether or not care meets acceptable standards.

   The CMO shall implement an effective QI program that aims to achieve significant improvement sustained over time, through ongoing measurements and CMO interventions, related to member health, functioning and satisfaction. Significant improvement for a particular indicator is defined either as reaching a specific target or as improving performance by a fixed percentage defined in advance by the CMO, or by DHFS. The CMO shall evaluate the overall effectiveness of its QA/QI program annually to determine whether the program has achieved significant improvement, where needed, in the quality of service provided to its members.

3. *Department Review and Audit*
   The CMO's organizational structure, standards, policies and practices shall allow for individualization to achieve member-defined outcomes. Whenever possible, the CMO shall demonstrate a direct connection between organizational actions and member defined outcomes. DHFS will determine the effectiveness of the CMO by evaluating its progress towards achieving personal outcomes for its members. On an annual basis, DHFS shall draw a random sample of all CMO members enrolled, for voluntary participation in the Family Care member outcome interviews. The CMO shall designate a staff person to act as an interview scheduler. The CMO scheduler will contact all members in the CMO sample and arrange member interviews and follow up interviews with the member's primary care manager, according to guidelines forwarded by DHFS. Upon conclusion of the interviews, DHFS shall

generate a report based on the results of all of the member outcome interviews and forward the report to the CMO. DHFS shall also forward CMO specific results on the presence or absence of the member-defined outcomes and supports provided to the CMO in a computerized spreadsheet format. The CMO shall use their specific results on member outcomes in conjunction with data from their provider network, claims data, etc. to conduct further analysis to assist in the identification of QA/QI performance improvement efforts.

The CMO shall have documentation of all aspects of the QA/QI program available for Department review upon request. DHFS may perform off-site and on-site QA/QI audits to ensure that the CMO is in compliance with the requirements of this contract. The review and audit may include: on-site visits; staff and member interviews; record reviews; review of QA/QI procedures, reports, committee activities, corrective actions and follow up plans; peer review process; review of the results of the member satisfaction surveys; and review of CMO staff and provider qualifications.

4. *QA/QI Performance*
   The CMO shall achieve required minimum levels of performance on specific measures that may be established and shall submit data specified by the DHFS that enables the DHFS to measure the CMO's performance. The CMO shall measure and report such performance to DHFS, using standard measures required by the DHFS or any national performance measures and levels that may be identified and developed by CMS in consultation with the States and other relevant stakeholders. The CMO shall meet any goals for performance improvement on specific measures that may be established by DHFS or CMS. See Addendum II., *CMO Quality Indicators* (page 132) for more information.

   a. The Family Care Program strives to achieve optimum vaccination rates among its members. For influenza, this vaccination rate is 90 percent among all members enrolled during the period from September through December of each calendar year. For pneumonia, the optimum vaccination rates are 90 percent among all members aged 65 or older and 90 percent among all members under the age of 65 who meet the criteria of high risk, as defined by the Centers for Disease Control.

      i. For the 2007 contract year, each CMO shall achieve a measured influenza vaccination rate among its members that is at least halfway between the rate measured among that CMO's members in 2005 and the optimum vaccination rate of 90 percent.

      ii. For the 2007 contract year, each CMO shall achieve a measured pneumonia vaccination rate among its members aged 65 and older that is at least halfway between the rate measured among that CMO's members in 2005 and the optimum vaccination rate of 90 percent.

5. *QA/QI Administrative Structure*
   The CMO's QA/QI program shall be administered through clear and appropriate administrative arrangements, such that:

   a. The governing board oversees and is accountable for the QA/QI program.

   b. A designated senior manager, who has direct authority to commit CMO resources to the QA/QI effort, is responsible for QA/QI implementation.

   c. The staffing level and available resources shall be sufficient to provide reasonable assurance that compliance with QA/QI standards is achieved within the maximum permissible time frame (a period to be established by DHFS).

   d. A QA/QI committee or other coordinating structure (that includes both administrative personnel and providers) shall exist to clearly identify individuals or organizational components responsible for each aspect of the QA/QI program and ensure that effective organizational structures are in place to facilitate communication and coordination.

   e. The QA/QI program shall include active participation by:

      i. Members or other individuals who meet the functional eligibility for the CMO's target population(s);

      ii. CMO staff and providers, including attendants and informal caregivers who are able to contribute to the QA/QI effort; and,

      iii. Long-term care and health care providers with professional expertise appropriate to the services offered by the CMO.

   f. There shall be collaboration among all aspects of the QA/QI activity and other functional areas of the CMO impacting the quality of service delivery and clinical care (e.g., utilization management, risk management, appeals and grievances, etc.).

6. *QA/QI Program Records*
   The activities of the QA/QI program shall be documented. These documents shall be available to DHFS upon request.

7. *Delegation*
   The CMO shall oversee and be wholly accountable for any functions or responsibilities that are described in these QA/QI standards and are delegated to any subcontractor. Specific responsibilities of the CMO are:

   a. Before any delegation, the CMO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;

b. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate;

c. The CMO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review at least once a year; and,

d. If the CMO identifies deficiencies or areas for improvement, the CMO and the subcontractor shall take corrective action.

8. *Performance Improvement Project*
Each performance improvement project must be completed (i.e. fully implemented) in a reasonable time period.

Annually, the CMO shall provide to the State the status and results of each project. Specifically, from performance improvement projects underway or information on projects that have been initiated, the CMO must report new information in enough detail to show that the CMO is progressing towards full implementation of each project.

The Department as part of its review of the impact and effectiveness of the CMO's internal quality assurance and quality improvement program shall review the results of the CMO's performance improvement projects at least annually. The requirements for the Performance Improvement Projects are addressed in Addendum VII., *Performance Improvement Projects* (page 159).

## B. Member Input

1. *Communication Processes*
The language and practices of the CMO shall recognize each member as an individual and emphasize each member's capabilities. CMO staff shall demonstrate dignity and respect their interactions with members.

2. *Ongoing Member Participation*
The CMO shall create a means for members to continually participate in CMO quality improvement and give input and feedback on the quality of the CMO services. Some methods for this ongoing member participation, feedback and input include: focus groups; consumer advisory councils; member participation on the governing board; the QA/QI committee or other committees; surveys of members who disenrolled; or task forces related to evaluating services. The CMO shall reach out to diverse member populations, such as frail, homebound members, to provide opportunities for participation, input, or feedback. Documentation of outreach efforts to solicit feedback from members shall be available to DHFS upon request.

3. *Annual Member Feedback on CMO Performance*
   In addition to the ongoing member participation described above, at least annually the CMO must seek formal member input, through member surveys, face-to-face interviews or other means, on:

   a. The effectiveness of its communications with members;

   b. Access and availability for services in and outside of the LTC benefit package;

   c. Choice and continuity;

   d. Changes in functional and health status of members; and,

   e. Other information of interest to consumers.

   The results of the annual member feedback on CMO performance shall be made available to DHFS and members upon request. The purpose of this activity is to identify successes, potential problems and barriers to care and to provide potential members with information they need to choose a CMO.

   The CMO shall have systems in place for acting on member feedback in a timely way, and shall report to DHFS the results and any quality management projects planned in response to the results. The annual member feedback activity can be used to obtain information for a Performance Improvement Project, as discussed in Addendum VII., *Performance Improvement Projects* (page 159).

**C. Provider Selection and Retention**

The CMO shall implement written policies and procedures for a provider selection and retention process that meets the requirements of this section.

1. For all providers who have signed contracts or participation agreements the initial selection process and reassessment at specified intervals shall be accomplished to ensure that, at a minimum, the provider is licensed (if DHFS requires licensing to operate in the State) and is in compliance with any other Federal or State requirements.

2. That the CMO monitors the performance of providers on an ongoing basis and through a process that updates information obtained during the initial selection process and considers performance indicators, including those obtained through the following:

   - The QA/QI program;

   - The utilization management system;

   - The appeal and grievance system;

- Member satisfaction surveys; and,

- Other CMO activities.

3. If the CMO identifies deficiencies or areas for improvement, the CMO and the provider take corrective action.

4. Discrimination Prohibited
   The CMO's use of formal selection and retention criteria shall not discriminate against particular practitioners or other providers, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

5. The CMO may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

**D. Availability of Member Records**

Member records must be readily available for CMO-wide QA/QI and Utilization Management activities. (See Article III.A. (6), Authorization of Services and Utilization Management, page 19.)

**E. External Quality Review**

1. *Assistance to Department and External Quality Review*
   The CMO shall assist DHFS and the external quality review organization under contract with DHFS in identification of provider and member information required to carry out on-site or off-site member record reviews. The provider of service may elect to have member records reviewed on-site or off-site.

2. *CMO's Tasks*
   When the external quality review organization under contract with DHFS identifies quality deficiencies which need to be followed up on, the CMO shall be responsible for the following tasks:

   a. Assign a staff person(s) to conduct follow-up with the CMO manager or the CMO provider(s) concerning each quality deficiency identified by the DHFS external quality review organization, including informing the provider(s) of the finding and monitoring the provider's resolution of the finding. Follow up with the appropriate CMO manager is conducted when the service is directly provided by the CMO. Follow up with the CMO provider is conducted when the service is subcontracted;

   b. Inform those participating in the CMO's QA/QI program of the follow up activities and final findings. Involve those participating in the QA/QI program in the development, monitoring, and resolution of the corrective action plan; and,

c. Submit a corrective action plan or an opinion in writing to DHFS within sixty (60) calendar days that describes the measures that the CMO and the provider intend to take to resolve the finding. The CMO's final resolution of all potential Quality Improvement cases must be completed within six (6) months of the notification to the CMO. A case is not considered resolved by DHFS until DHFS approves the response submitted by the CMO and provider.

3. *Training*
The CMO shall facilitate training provided by DHFS to the CMO's providers.

4. *Availability of Results*
The results of the review shall be made available to DHFS, CMO providers, and members in a manner that does not disclose the identity of any individual member.

## VII. CMO Functions: Administration

### A. Financial Management

1. *Elements of Financial Management*
The CMO is responsible for sound financial management practices which maximize the value and quality of services provided for the funds expended. The CMO's financial management systems shall include the following at a minimum:

a. Systems to ensure that information used for financial management and reporting purposes is timely, accurate and complete;

b. An accounting system adequate to manage the business needs of a managed care organization;

c. Policies and procedures to ensure effective cost control;

d. Policies and procedures regarding the accumulation and appropriate utilization of the solvency protections as specified in Addendum III., *Capacity for Financial Solvency and Stability* (page 135); and,

e. Practices to ensure the cost-effective use of available resources, including per member per month payments (Article IX.A., *Per Member Per Month Payment Rates*, page 104), Medicare and other third party liability payment sources, 1915 (c) waiver post eligibility treatment of income (Article III.A. (16), *Billing Members*, page 24), and private pay care management (Article III.A. (20), *Private Pay Care Management,* page 29).

2. *Budget*
The CMO shall develop a budget for the contract year, which receives approval from DHFS prior to the effective date of this contract. The budget shall be prepared using the financial statement format mutually agreed to by the CMO and DHFS, found in

Article X.B. (2), *Reports and Data* (page 108) and contain the following elements at a minimum:

a. A three-year monthly enrollment plan of census projections, showing the CMO's steps toward serving the target population(s) in a timeframe agreed upon with DHFS. Additionally, the levels of care, comprehensive, intermediate or grandfather will be identified for the target population(s) in the projections;

b. Monthly budget projections, including detailed member service costs, care management costs, administrative expenses including plans for additional interdisciplinary teams and other staff necessary to serve the added enrollment, expenses for Information Technology improvements, all other indirect and direct administrative costs;

c. Monthly revenue projections. Both b. & c. should be in the CMO Income Statement format which the CMO plans to use for 2007 so that budget vs. actual statements can be generated monthly; and,

d. Notes to the budget should include a detail of the budget assumptions including major strategic initiatives for the upcoming contract year, cost savings initiatives, staffing changes, technology improvement, etc. along with associated costs/benefits of the initiatives.

3. *Enrollment Plan Updates*
The CMO shall submit updated, three year monthly enrollment plans as described in above after the effective date of the contract on March 1, 2007 and prior to the end of the current contract period, September 1, 2007.

**B. Member Records**

The CMO shall have a system for maintaining member records and for monitoring compliance with their policies and procedures.

1. *Confidentiality*
The CMO shall implement specific procedures to assure the confidentiality of health and medical records and of other personal information about members, including:

a. Members have the right to approve or refuse the release of personally identifiable information, except when such release is authorized by law;

b. Original medical records shall be released only in accordance with federal or state law, or court orders or subpoenas;

c. Copies of records and information from the CMO shall be released only to authorized individuals; and,

d. Unauthorized individuals shall be prohibited from gaining access to, or altering, member records.

2. *Member Access to Records*
   Members shall have access to their records in accordance with applicable state or federal law. The CMO shall use best efforts to assist a member, his/her authorized representatives, and others designated by the member to obtain records within ten (10) business days of the request. The CMO shall identify an individual who can assist the member and his/her authorized representatives in obtaining records.

3. *Medical Information Available to CMOs*
   The CMO is a contractor of the State and is therefore entitled to obtain records according to HFS 104.01 (3) Wis. Adm. Code, on Confidentiality of Medical Information. DHFS requires Medicaid-certified providers to release relevant records to the CMO to assist in compliance with this section. Where the CMO has not specifically addressed photocopying expenses in their provider, subcontracts or other arrangements, the CMO is liable for charges for copying records only to the extent that DHFS would reimburse on a fee-for-service basis.

4. *Care of Records*
   Member records shall be accurate, legible and safeguarded against loss, destruction, or unauthorized use.

5. *Maintain Complete Records*
   Documentation in member records must reflect all aspects of care, including documentation of assistance with transitional care in the event of a disenrollment. Member records must be readily available for member encounters, and for administrative purposes.

6. *Professional Standards*
   The CMO shall maintain, or require the CMO subcontractors to maintain, individual member records in accordance with established professional standards, for each member. The CMO shall make all pertinent and sufficient information relating to the management of each member's medical and long-term care readily available to DHFS and to appropriate health professionals.

7. *Provision of Records*
   The CMO shall have procedures to provide copies of records promptly to other non-CMO providers for the management of the member's medical and long-term care, and the appropriate exchange of information among the CMO and non-CMO providers receiving referrals.

8. *Records Available for QA/QI and Utilization Review*
   Member records shall be readily available for CMO-wide QA/QI and Utilization Review activities. The member records shall provide adequate medical and long-term care service information, and other clinical data needed for QA/QI and Utilization Review purposes, and for investigating member appeals and grievances.

9. *Continuity of Records*
   The CMO shall have adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

10. *Contents of Member Records*
    A member record shall contain at least the following items:

    a. Face Sheet of demographic information;

    b. Consent forms;

    c. Family Care Comprehensive Health Assessment;

    d. Family Care Comprehensive Social Assessment;

    e. Documentation of re-assessment(s);

    f. Individual Service Plan;

    g. Member-Centered Plan;

    h. Advance directive (if there is one completed);

    i. Guardianship, power of attorney (if there is one completed);

    j. Case notes by CMO interdisciplinary team members;

    k. Cost share forms/documentation (if there is any);

    l. Notice of Change forms (if there are any);

    m. Signed Enrollment Request; and,

    n. Reports of consultations.

    Minimum member record documentation per chart entry or encounter must conform to the applicable provisions of s. HFS 106.02 (9), Medical and Financial Record Keeping, Wis. Adm. Code.

**C. Accessibility of Language**

The CMO shall provide materials in formats accessible due to language spoken and various impairments, including but not limited to Braille and large print. Materials shared with potential members and members shall be understandable in language and format based on the following:

1. Material directed at a specific member (e.g., written communication of intention to deny a service): shall be in the language understood by the individual.

2. Material directed at potential members or members in general (e.g., member handbook): shall be provided in languages prevalent in the CMO service area, and in accessible formats (e.g., Braille, large print).

3. All materials: shall be in easily understood language and format. Materials shall take into account individuals with limited reading proficiency.

4. The CMO shall provide instructions to members and potential members in the materials on how to obtain information in the appropriate language or accessible format (e.g., sign language) and how to access such translation/interpreter services.

**D. Affirmative Action and Civil Rights Compliance Plan**

1. *Requirement for Affirmative Action and Civil Rights Compliance Plan*
An Affirmative Action and Civil Rights Compliance Plan is required from any CMO that receives a contract from the Department in the amount of $25,000 or more and that has a work force of twenty-five (25) or more employees as of the effective date of this contract. CMOs having less than 25 employees, or receiving less than $25,000 in funding shall submit a Letter of Assurance. CMOs shall submit an Affirmative Action and Civil Rights Compliance Plan or Letter of Assurance as required by the Department of Workforce Development and Department of Health and Family Service's Affirmative Action and Civil Rights Compliance Requirements in effect during the contract period. The most current three-year plan can be accessed through the Department of Health and Family Services, Office of Affirmative Action and Civil Rights Compliance, P.O. Box 7850, 1 West Wilson Street, Madison, WI 53707-7850, (608)-266-9372 (Voice), (608)-267-2147 (Fax), (888)-701-1251(TTY), or through the internet at: http://dhfs.wisconsin.gov/civilrights. The Affirmative Action and Civil Rights Compliance Plan must meet the requirements under Title VI and Title VII of the Civil Rights Act of 1964, Section 503 and 504 of the Rehabilitation Act of 1973, Title VI and XVI of the Public Health Service Act, the Age Discrimination in Employment of 1967, the Age Discrimination Act of 1975, the Omnibus Reconciliation Act of 1981m, the American with Disability Act (ADA) of 1990, the Wisconsin Fair Employment Act and s.16.765 Wis. Stats., and ADM 50.

   These requirements may be satisfied if the CMO is included in or covered by a Civil Rights Compliance Plan or Civil Rights Compliance Letter of Assurance submitted by a County or other Municipality of which it is a part.

2. *Discrimination in Services Prohibited*
   No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination in any manner on the basis of race, color, national origin, religion, sex, disability or age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities. All employees of the CMO are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

3. *Employment Discrimination Prohibited*
   No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subjected to discrimination in employment in any manner or term of employment on the basis of age, race, religion, sexual orientation, color, sex, national origin or ancestry, handicap (as defined in Section 504 of the Rehabilitation Act of 1973 and the American Disability Act of 1990), or association with a person with a disability arrest or conviction record, marital status, political affiliation, military participation, unfair honesty testing and genetic testing, or use of lawful products outside of working hours. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

4. *Equal Opportunity Policy*
   The CMO shall post the Equal Opportunity Policy, the names of the Equal Opportunity Coordinator and the Limited English Proficiency Coordinator, and discrimination complaint process in conspicuous places available to applicants and people who use the CMO's services, and applicants for employment, and employees. The complaint process will be according to Department standards and translations of the complaint process notice from English into the major primary languages of the limited English Proficient (LEP) clients in the CMO's service area shall be posted in conspicuous places available to applicants and people who use the CMO's services. The complaint process notice will announce the availability of free oral interpretation of services if needed. The CMO shall not request interpretation services from family members, friends, or minors. DHFS will continue to provide appropriate translated program brochures and forms for distribution.

5. *CMO to Comply with DHFS Guidelines for Civil Rights Compliance*
   The CMO agrees to comply with the Department's guidelines found in the most current State of Wisconsin Department of Workforce Development and Department of Health and Family Services, Affirmative Action, Equal Opportunity, Limited English Proficiency, and Civil Rights Compliance Plan for the funding period of January 1, 2007 to December 31, 2009.

6. *Subcontract Providers*
   Requirements herein stated apply to any subcontracts or grants. The CMO has primary responsibility to take constructive steps, as per the State of Wisconsin Department of Workforce Development and Department of Health and Family Services, Affirmative Action, Equal Opportunity, Limited English Proficiency, and Civil Rights Compliance Plan for the funding period of January 1, 2007 to

December 31, 2009, to ensure the compliance of its subcontractors. However, where DHFS has a direct contract with the CMO's subcontractor, including certification as a Medicaid provider, DHFS assumes responsibility for reviewing and approving the CMO's subcontractor's Plan. However, the CMO must request a copy of the Civil Rights compliance Plan or Letter of Approval from the subcontractor to verify the subcontractor's compliance.

7. *DHFS Monitoring*
   DHFS will monitor the Civil Rights Compliance of the CMO. DHFS will conduct reviews to ensure that the CMO is ensuring compliance by its subcontractors according to guidelines in the State of Wisconsin Department of Workforce Development and Department of Health and Family Services, Affirmative Action, Equal Opportunity, Limited English Proficiency, and Civil Rights Compliance Plan for the funding period of January 1, 2007 to December 31, 2009. The CMO agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the CMO, as well as interviews with staff, clients, applicants for services, subcontractors, grantees and referral agencies. The reviews will be conducted according to Department procedures. DHFS will also conduct reviews to address immediate concerns of complainants.

8. *Corrective Action Plan*
   The CMO agrees to cooperate with DHFS in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

9. *CMO Responsibilities*
   The CMO agrees that it will:

   a. Hire staff with non-English skills, sign language skills and/or provide staff with special translation or sign language skills training, or find qualified persons who are available within a reasonable period of time and who can communicate with limited- or non-English speaking or speech- or hearing-impaired clients at no cost to the client;

   b. Provide aids, assistive devices and other reasonable accommodations to the client during the application process, in the receipt of services, and in the processing of grievances or appeals;

   c. Provide training on Civil Rights Compliance to staff including human relations techniques, sensitivity to persons with disabilities and cultural sensitivity and awareness once every three years;

   d. Make programs and facilities accessible, as appropriate, through outstations, authorized agents or employees, adjusted work hours, ramps, doorways, elevators, or ground floor rooms, and Braille, large print or taped information for the visually or cognitively impaired;

e. Post and/or make available informational materials in languages and formats appropriate to the needs of the target populations; and,

f. Provide aids, assistive devices and other reasonable accommodations to the client

**E. Ineligible Organizations**

Upon obtaining information or receiving information from DHFS or from another verifiable source, the CMO shall exclude from participation in the CMO all organizations which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. *Ineligibility*

Entities which could be excluded under Section 1128 (b) (8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of five percent or more in the entity, or a person with beneficial ownership or control interest of five percent or more in the entity has:

a. Been convicted of the following crimes:

i. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid (see Section 1128 (a) (1) of the Act);

ii. Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128 (a) (2) of the Act);

iii. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (see Section 1128 (b) (1) of the Act);

iv. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above (see Section 1128 (b) (2) of the Act); or,

v. Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128 (b) (3) of the Act).

b. Been Excluded from Participation in Medicare or a State Health Care Program. A State health care program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128 (b) (8) (iii) of the Act.)

c. Been Assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128 (b) (8) (B) (ii) of the Act.)

2. *Contractual Relations*
Entities which have a direct or indirect substantial contractual relationship with an individual or entity listed above in subsection (a). A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

a. The administration, management, or provision of medical or long-term care services;

b. The establishment of policies pertaining to the administration, management, or provision of medical or long-term care services; or,

c. The provision of operational support for the administration, management, or provision of medical or long-term care services.

3. *Excluded Medicaid*
Entities which employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A of the Act, for the provision (directly or indirectly) of Health Care, Utilization Review, Medical Social Work or Administrative Services. For the services listed, the CMO shall exclude from contracting with any entity which employs, contracts with, or contracts through an entity which has been excluded from participation in Medicaid by the Secretary under the authority of Section 1128 or 1128A of the Act.

The CMO attests by signing this contract that it excludes from participation in the CMO all organizations which could be included in any of the above categories.

**F. Compliance with Applicable Law**

The CMO shall observe and comply with all Federal and State law in effect when this contract is signed or which may come into effect during the term of this contract, which in any manner affects the CMO's performance under this contract, except as specified in Article III.A., *Provision of Services in the LTC Benefit Package* (page 16), including the Byrd Anti-Lobbying Amendment, the Clean Air Act and Federal Water Pollution Control Act and the rights of the federal government and CMO members to inventions in accordance with 37 CFR part 401.

## G. Clinical Laboratory Improvement Amendments

When coordinating laboratory services, the CMO shall use only laboratories that have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate along with a CLIA identification number and that comply with the CLIA regulations as specified by 42 CFR 493, "Laboratory Requirements." Those laboratories with certificates will provide only the types of tests permitted under the terms of 42 CFR 493.

## H. Annual Audit

1. *Requirement to Have an Audit*
   The CMO shall submit an annual audit as described in the current Family Care Audit Guide, which is now included in the "Appendix to the State Single Audit Guidelines for Programs from the Department of Health and Family Services." The current SSAG appendix for DHFS can be located in the reference center at: http://www.doa.state.wi.us.

   The report is due to the Department within 180 days of the end of the agency's fiscal period. However, if the CMO is audited as part of the county audit, the deadline for the Family Care CMO audit is the deadline for the county audit, which is nine months from the end of the fiscal period.

2. *Audit Requirements*
   The audit shall be an audit in accordance with the Government Auditing Standards issued by the United States General Accounting Office of the Year-end Financial Statement prepared by the CMO on an accrual basis of accounting. The audit must include testing of compliance with program and financial requirements in the current Family Care Audit Guide. If the CMO is governed by a single county, the audit of the CMO may be a part of the county's annual audit.

   The per member per month payments (PM/PM) made by DHFS to the CMO are not defined as Federal financial assistance for purposes of determining whether the audit needs to be in accordance with OMB Circular A-133.

3. *Submitting the Reporting Package*
   The reporting package must include:

   a. Financial statements other than audit schedules and reports required for the type of audit necessary for the CMO entity.
   b. A Management Letter (or similar document conveying auditor's comments issued as a result of the audit) or written assurance that a Management Letter was not issued with the audit report.
   c. Management responses/corrective action plan for each audit issue identified in the audit report and/or the Management letter.

   Two copies of the audit report shall be sent to DHFS at the following address:

Office of Audit
Division of Management and Technology
Department of Health and Family Services
P.O. Box 7850
Madison, WI 53707-7850
Telephone: (608) 267-2836

4. *Access to Auditor's Work Papers*
When contracting with an audit firm, the CMO shall authorize its auditor to provide access to work papers, reports, and other materials generated during the audit to the appropriate representatives of DHFS. Such access shall include the right to obtain photocopies of the work papers and computer disks, or other electronic media, upon which records/working papers are stored.

5. *Access to Agency Premises and Records*
The CMO shall allow duly authorized agents or representatives of DHFS or the Federal government, during normal business hours, access to the CMO's premises (or to any subcontractor's premises) to inspect, audit, monitor or otherwise evaluate the performance of the CMO's or subcontractor's contractual activities and shall within a reasonable time, but not more than ten (10) business days, produce all records requested as part of such review or audit. In the event right of access is requested under this provision, the CMO or subcontractor shall, upon request, provide and make available staff to assist in the audit, evaluation, or inspection effort, and provide adequate space on the premises to reasonably accommodate DHFS or Federal personnel conducting the audit, evaluation, or inspection effort. All inspections, evaluations, or audits shall be conducted in a manner as will not unduly interfere with the performance of CMO's or subcontractor's activities.

6. *Failure to Comply with the Requirements of this Section*
In the event that the CMO fails to have an appropriate audit performed or fails to provide a complete audit report to DHFS within the specified timeframes, in addition to applying one or more of the remedies available under this contract, DHFS may:

   a. Conduct an audit or arrange for an independent audit of the CMO and charge the cost of completing the audit to the CMO; and/or,

   b. Charge the CMO for all loss of Federal or State aid or for penalties assessed to DHFS because the CMO did not submit a complete audit report within the required timeframe.

## I. Access to Premises and Information

1. *Access to Premises*
The CMO shall allow duly authorized agents or representatives of the State or Federal government, during normal business hours, access to the CMO's premises or the CMO subcontractors' premises to inspect, audit, monitor or otherwise evaluate the performance of the CMO's or subcontractors' contractual activities and shall

forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the CMO or subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. DHFS may perform off-site audits or inspections to ensure that the CMO is in compliance with contract requirements.

All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the CMO's or subcontractor's activities. The CMO shall be given fifteen (15) business days to respond to any findings of an audit before DHFS shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

2. *Access to and Audit of Contract Records*
Throughout the duration of this contract, and for a period of five years after termination of this contract, the CMO shall provide duly authorized agents of the State or Federal government access to all records and material relating to the contract's provision of and reimbursement for activities contemplated under this contract. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of this contract. All information so obtained will be accorded confidential treatment as provided under applicable law.

**J. Program Integrity Plan, Program and Coordination**

The CMO's governing board or its designee shall approve a written Program Integrity work plan that is developed by the designated CMO program integrity compliance officer and compliance committee. The plan will describe the CMO's commitment to operational initiatives designed to prevent, detect, and correct instances of fraud and abuse including details describing the scope of activity, goals, objectives and timelines associated with the monitoring program. The Program Integrity plan must be submitted to DHFS and approved on an annual basis prior to the effective date of the new contract year. (See Addendum IX., *CMO Certification and Re-Contracting*, page 166).

1. *Definitions*

   a. "Fraud" means an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to him/herself, itself or to some other person or entity. It includes any act that constitutes fraud under applicable Federal or State law.

   b. "Abuse' means any practice that is inconsistent with sound fiscal, business or medical practices and results in unnecessary program costs.

2. *Written Procedures*
The CMO, with technical assistance from the Department shall have written policies and procedures that relate to the following:

a. Conducting regular reviews and audits of operations.

b. Assessing and strengthening internal controls.

c. Educating employees, network providers and members about fraud and abuse and how to report it.

d. Effectively organizing resources to respond to and process complaints of fraud and abuse.

3. *Reporting*

a. The CMO shall report any suspected fraud and abuse involving the Family Care program to the CMO Contract Administrator as soon as possible, but within ten (10) days.

b. Quarterly, as specified in Article X.B. (3), page 109, the CMO shall submit a report to DHFS describing any instances of fraud and abuse that arose during the quarter, the timeline in which it was handled the outcome and whether any corrective action was taken.

c. The CMO shall comply with any other Federal, State or local requirements for reporting fraud and abuse.

4. *Investigations*
The CMO shall cooperate with any investigation of fraud and abuse, including directly conducting investigations as needed. The CMO shall assist the Department and any other entity legally authorized to investigate fraud and abuse in determining any amounts to be repaid, and with other follow up as requested.

## VIII. Functions and Duties of DHFS

In consideration of the functions and duties of the CMO contained in this contract:

**A. Bureau of Long-Term Support**
The Bureau of Long-Term Support (BLTS), in the Division of Disability and Elder Services, is the primary point of contact between DHFS, the CMO and other portions of DHFS and DHFS's contract agencies charged with responsibility for administration and implementation of Family Care. BLTS shall assist the CMO in identifying system barriers to implementation of Family Care and shall facilitate intra- and interagency communications and work groups necessary to accomplish full implementation.

**B. Reports from the CMOs**
DHFS shall have systems in place to ensure that reports and data required to be submitted by the CMO shall be reviewed and analyzed by DHFS in a timely manner. DHFS shall respond accordingly to any indications that the CMO is not making progress toward

meeting all performance expectations (e.g., providing timely and accurate feedback to the CMO, and offering technical assistance to help the CMO correct any operational problems).

**C. Enrollment**

DHFS shall notify the CMO two times per month of all members enrolled in the CMO under this contract. Notification shall be effected through CMO Enrollment Reports. All members listed as an ADD or CONTINUE on either the Initial or Final CMO Enrollment Reports are members of the CMO during the enrollment month. The reports shall be generated in the sequence specified under the CMO Enrollment Reports. The CMO shall review the Enrollment Reports upon receipt and report inaccuracies to DHFS as soon as possible but no later than 90 days following receipt of the reports. These reports shall be in a proprietary or HIPAA compliant format according to MMIS standards.

**D. Forward ID Cards**

For those members eligible for Medicaid DHFS will issue new members a Family Care Forward card which will provide indication to the provider of the member's enrollment in the specific CMO. This card will be issued after enrollment. The card will be a blue, plastic, magnetic stripe identification card.

**E. Disenrollment**

DHFS will promptly notify the CMO of all members no longer eligible to receive services through the CMO under this contract. Notification shall be effected through the CMO Enrollment Reports that DHFS will transmit to the CMO for each month of coverage throughout the term of the contract. The reports shall be generated in the sequence under the CMO Enrollment Reports. Any member who was enrolled in the CMO in the previous enrollment month, but does not appear as an ADD or CONTINUE on either the Initial or Final CMO Enrollment Report for the current enrollment month, is disenrolled from the CMO effective the last day of the previous enrollment month. See Article III.A (7), *Payment for Services* (page 20), regarding conditions for members who continue to have a valid Family Care ID card.

**F. Enrollment Reports**

For each month of coverage throughout the term of this contract, DHFS shall transmit CMO Enrollment Reports to the CMO. These reports will provide the CMO with ongoing information about its members and disenrollees and will be used as the basis for the monthly per member per month claims described in Article IX.E., *Payment Schedule* (page 105). Enrollment Reports will be generated in the following sequence:

1. *Initial Report*
   The Initial CMO Enrollment Report will list all of the CMO's members and disenrollees for the current enrollment month who are known on the date of report generation. The Initial CMO Enrollment Report will be received by the CMO on or before the fifth day of each month covered by the contract. Each member listed as an ADD or CONTINUE on this report will be listed on the payment report. Members who appear as PEND/CLOSE/DISENROLL on the Initial Report and are reinstated

into the CMO during the month will appear as an ADD or CONTINUE on the Final Report.

2. *Final Report*
   The final CMO Enrollment Report will list all of the CMO's members for the enrollment month, who were not included in the Initial CMO Enrollment Report. The Final CMO Enrollment Report will be received by the CMO on or before the fifteenth day of each month subsequent to the coverage month. Each member listed as an ADD or CONTINUE on this report will be listed on the payment report. Members in PEND/CLOSE/DISENROLL status will not be included on the final report.

**G. Utilization Review and Control**

DHFS shall waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of services in the LTC benefit package provided by the CMO to members.

**H. Right to Review**

DHFS will submit to the CMO for prior approval materials that describe the CMO and that will be distributed by DHFS or County to potential members and members.

**I. Review of Study or Audit Results**

DHFS shall submit to the CMO for a fifteen (15) business day review/comment period, any studies or audits that are going to be released to the public that are about the CMO and Medicaid.

**J. Technical Assistance**

DHFS shall review reports and data submitted by the CMO and shall share results of this review with the CMO. In conjunction with the CMO DHFS shall determine whether technical assistance may be available to assist in improving performance in any areas of identified need. DHFS, in consultation with the CMO shall develop a technical assistance plan and schedule to assure compliance with all terms of this contract and quality service to members of the CMO.

**K. Remedies for Violation, Breach, or Non-Performance of Contract**

1. *Basis for Imposition of Sanctions - Service Delivery*
   DHFS may impose sanctions as set forth in subsection (2) below only if the CMO acts or fails to act as follows:

   a. Fails substantially to provide necessary services that the CMO is required to provide, under law or under the terms of this contract, to a member covered under this contract**,** or fails substantially to meet quality standards and performance criteria of this contract such that members are at substantial risk of harm.

   b. Imposes on any member premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program and this contract.

c. Acts to discriminate among members on the basis of their health status or requirements for services. This includes termination of enrollment or refusal to reenroll a member, except as permitted under the Medicaid program and this contract, or any practice that would reasonably be expected to discourage enrollment by recipients whose condition or history indicates probable need for substantial future services.

d. Misrepresents or falsifies information that it furnishes to the Department or CMS or to a member, potential member, or a provider.

e. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or contain false or materially misleading information.

2. *Types of Sanctions - Service Delivery*
DHFS may impose sanctions as set forth below for action or a failure to act as set forth in subsection (1) above.

a. *Suspension of New Enrollment*
Whenever the CMO has acted or failed to act in accordance with subsection (1) (a-e) above, DHFS may suspend the CMO's right to receive new enrollment under this contract. DHFS, when exercising this option, must notify the CMO in writing of its intent to suspend new enrollment at least thirty (30) calendar days prior to the beginning of the suspension period. The suspension will take effect if the action or failure to act remains uncorrected at the end of this period. DHFS may suspend new enrollment sooner than the time period specified in this paragraph or appoint Temporary Management as described below if DHFS finds that member long-term care, health or welfare is jeopardized or if the CMO is unable to comply with Federal or State law. The suspension period may be for any length of time specified by DHFS, or may be indefinite. The suspension period may extend up to the expiration of the contract as provided under Article XVI., *CMO Specific Contract Terms*, (page 119).

b. *Department-Initiated Enrollment Reductions*
DHFS may reduce the maximum enrollment level and/or number of current members whenever the CMO has failed to provide one or more of the services necessary to achieve outcomes in the LTC benefit package required under Article III.A., *Provision of Services in the LTC Benefit Package* (page 16), or that the CMO has failed to maintain or make available any records or reports required under this contract which DHFS needs to determine whether the CMO is providing the services as required under Article III.A. (page 16).

The CMO shall be given at least thirty (30) calendar days to correct the lack of necessary services prior to DHFS taking any action set forth in this paragraph. DHFS may reduce enrollment or appoint Temporary Management as set forth below sooner than the time period specified in this paragraph if DHFS finds that

member long-term care, health or welfare is jeopardized or if the CMO is unable to comply with Federal or State law.

c. *Withholding of Per Member Per Month Payments and Orders to Provide Services*
Notwithstanding the provisions of Article IX., *Payment to CMO* (page 104), with written notice to the CMO describing such grounds and absent the CMO's prompt and reasonable efforts to remove the grounds described, DHFS may withhold portions of per member per month payments as liquidated damages or otherwise recover damages from the CMO on the following grounds:

i. Whenever the CMO has failed to provide one or more of the services necessary to achieve outcomes in the LTC benefit package, required under Article III.A., *Provision of Services in the LTC Benefit Package* (page 16) the Department may either order the CMO to provide such service, or withhold a portion of the CMO's per member per month payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.

ii. When the Department withholds payments under this section, the Department must submit to the CMO a list of the members for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide the services necessary to achieve outcomes.

iii. If the Department acts under this section and subsequently determines that the services in question were not covered services:

- In the event the Department withheld payments, it shall restore to the CMO the full per member per month payment; or,

- In the event the Department ordered the CMO to provide services under this section; it shall pay the CMO the actual documented cost of providing the services.

d. *Contract Termination*
If a basis for imposition of a sanction exists under subsection (1) above, the CMO may be subject to sanctions set forth above or to contract termination under Article XI., *Termination, Modification and Renewal of Contract* (page 112), or DHFS refusal to contract with the CMO in a future time period, as determined by DHFS The Department will select among these sanctions based upon the nature of the services in question, whether the failure or denial was an isolated instance or a repeated pattern or practice, and whether the long-term care or health of a member was injured, threatened or jeopardized by the failure or denial. This applies not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal has been made (i.e., the Department is knowledgeable about the documented abuse from other sources).

3. *Basis for Imposition of Sanctions - Administration*
   DHFS may impose sanctions as set forth in this subsection only if the CMO has acted or failed to act in accordance with the terms of this subsection, DHFS has informed the CMO of the problem and given the CMO a reasonable timeframe and a definite deadline by which to correct the problem on its own and offered and/or provided technical assistance and made recommendations to the CMO on how to correct the problem, and the problem persists either because the CMO refuses to accept technical assistance or fails to make reasonable efforts to implement the recommendations.

   a. If the CMO fails to submit required data and/or information to DHFS or to its authorized agents, or fails to submit such data or information in the required form or format, by the deadline provided for in this subsection, DHFS may impose liquidated damages in the amount of $100 per day for each day beyond deadline that the CMO fails to submit the data or fails to submit the data in the required form or format, such liquidated damages to be deducted from the CMO's per member per month payments.

   b. Whenever the CMO has failed to perform an administrative function required under this contract, the Department may withhold a portion of future per member per month payments. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services. The amount withheld by the Department under this section will be an amount that the Department determines in the reasonable exercise of its discretion to approximate the cost to the Department to perform the function. The Department may increase these amounts by 50 percent for each subsequent non-compliance.

   c. Whenever the CMO has failed to perform the administrative functions defined in Article IX.F., *Third Party Liability (TPL)* (page 105), the Department may withhold a portion of future per member per month payments sufficient to directly compensate the Department for the Medicaid program's costs of providing services and items to members insured by said insurers and/or the insurers/employers represented by said third party administrators.

4. *Notice of Sanctions*
   Before imposing any sanction specified in this Article, the Department must give the CMO thirty (30) calendar days written notice that explains the basis and nature of the sanction. If the Department determines conditions for Appointment of Temporary Management, the Department may not delay the imposition of temporary management during the time required for notice procedures as set forth in this section, and may not provide any hearing prior to imposition of temporary management.

5. *Notice to CMS*
   The Department must notify CMS no later than thirty (30) calendar days after the imposition or lifting of any sanction, said notice to include name of the CMO, the kind of sanction and the reason for the State's decision to impose or lift the sanction.

6. *Appointment of Temporary Management*

    a. The Department has the option to appoint temporary management of the CMO under the following circumstances:

        i. The CMO repeatedly fails to meet the requirements of this contract; and one of the following exists:

            - There is substantial risk to the health of the CMO's members; or,

            - There is a need to assure the health of the CMO's members during an orderly termination or reorganization of the CMO or improvements are being made to correct violations of this contract.

    b. Temporary management will not be removed until the Department determines the CMO has the capability to ensure the violations will not recur.

7. *Contract Termination*
   The Department may terminate this contract as specified in Article XI., *Termination, Modification and Renewal of Contract* (page 112).

8. *Authority of the Secretary*
   Section 1903 (m) (5) (B) (ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a CMO for members who enroll after the date on which the CMO has been found to have committed one of the violations identified in the Federal law. State payments for members of the CMO are automatically denied whenever, and for as long as, Federal payment for such members has been denied as a result of the commission of such violations.

9. *Authority of the Department*
   The Department may pursue all sanctions and remedial actions with the CMO that are taken with Medicaid fee-for-service providers. In any case under this contract where DHFS has the authority to withhold per member per month payments, DHFS also has the authority to use all other legal processes for the recovery of damages.

### L. Conflict of Interest

DHFS maintains that department employees are subject to safeguards to prevent conflict of interest as set forth in s. 19 Stats.

## IX. Payment to CMO

### A. Per Member Per Month Payment Rates (PMPMs)

In full consideration of services in the LTC benefit package rendered by the CMO, DHFS agrees to pay the CMO monthly payments based on the per member per month payment

rate specified in Addendum V. *Actuarial Basis* (page 142). The per member per month payment rate shall not include any amount for recoupment of losses incurred by the CMO under previous contracts.

**B. Actuarial Basis**

The per member per month payment rate is calculated on an actuarial basis (specified in Addendum V. *Actuarial Basis* (page 142) recognizing the payment limits set forth in 42 CFR 438.6(c).

**C. Renegotiation**

The monthly per member per month payment rates set forth in this Article shall not be subject to renegotiation during the contract term or retroactively after the contract term, unless such renegotiation is required by changes in Federal or State law.

**D. Reinsurance**

The CMO may obtain a risk-sharing arrangement from an insurer other than DHFS for coverage of members under this contract, provided that the CMO remains substantially at risk for providing services under this contract.

**E. Payment Schedule**

Payment to the CMO shall be based on CMO Enrollment Reports that DHFS will transmit to the CMO. The CMO shall accept payments under this contract as payment in full and shall not bill, charge, collect or receive any other form of payment from DHFS and the member except as permitted by Medicaid regulations as specified in Article III.A. (16), *Billing Members* (page 24).

**F. Third Party Liability (TPL) and Casualty Claims**

The CMO shall actively pursue, collect and retain any monies from third party payers for services in the LTC benefit package to members except where the amount of reimbursement the CMO can reasonably expect to receive is less than the estimated cost of recovery. The CMO shall report possible casualty collections in the Financial Report as required in Article X., *Reports and Data* (page 106) and be able to demonstrate that appropriate collection efforts were made and followed up on. The CMO shall establish policies and procedures to ensure coordination of third party liability.

TPL may include, but is not limited to, all other State or Federal medical care programs which are primary to Medicaid, group or individual health insurance and casualty collections.

A casualty collection means any recoverable amounts arising out of settlement of torts or Worker's Compensation. State subrogation rights have been extended to the CMO under ch. 49 Stats., including s. 49.89.

Collections from third party payers are the responsibility of the CMO or its subcontractors. The CMO and subcontractors shall not pursue collection from the member but directly from the third party payer.

### G. Recoupments

DHFS will not normally recoup per member per month payments made to the CMO when the CMO actually provided service or the person is subsequently determined ineligible. However, DHFS may recoup per member per month payments made to the CMO in the following situations:

1. *Change of Eligibility Status*
   DHFS will recoup per member per month payments made to the CMO when a member's status has changed because:

   a. The member voluntarily disenrolls;

   b. The member fails to meet functional or financial eligibility and the member has exhausted his/her grievances processes including a fair hearing which the member has requested;

   c. The member initiates a move out of the CMO service area;

   d. The member fails to pay, or to make satisfactory arrangements to pay, any cost share amount due the CMO after a thirty (30) calendar day grace period;

   e. The member dies; or,

   f. The member is ineligible for Medicaid as an Institutionalized Individual consistent with 42 CFR 435.1008 and as defined in 42 CFR 435.1009.

   No recoupment under this section will occur unless the CMO knew or should have known of such status change.

2. *Disputed Membership*
   When membership is disputed, DHFS shall be the final arbitrator of membership and reserves the right to recoup an inappropriate per member per month payment.

3. *Contract Termination*
   If this contract is terminated, recoupments will be accomplished through a payment by the CMO within thirty (30) calendar days of contract termination.

## X. Reports and Data

### A. Management Information System (MIS)

1. *MIS Requirements*
   The CMO shall meet all of the reporting requirements as specified in this contract in a timely way, assure the accuracy and completeness of the data, and submit the reports/data in a timely manner. Data submitted to DHFS shall be supported by records available for inspection or audit by DHFS. The CMO must be able to submit

data and/or reports to DHFS, or receive data and/or reports from DHFS in a secure format. The CMO shall designate a contact person responsible for data reporting who is available to answer questions from DHFS and resolve any issues regarding reporting requirements. The Chief Executive Officer or his/her designated person must certify the encounter data.

The CMO's Management Information System (MIS) shall be sufficient to support quality assurance/quality improvement requirements described in Article VI., *CMO Functions: Quality Assurance/Quality Improvement (QA/QI)* (page 79).

2. *Claims Processing*
   The CMO shall have a claims processing system which meets the specifications of Article V.C. (3), *Thirty Day Payment Requirement* (page 74), and (4), *Claims Retrieval System* (page 74).

3. *Encounter Reports*
   For reporting periods during the year 2007, the CMO shall report member-specific data on the Long-Term Care Encounter Data system as directed by DHFS. CMO staff will participate in the planning and development of data reporting requirements for implementation during the term of this contract consistent with all HIPAA requirements applicable to the CMO. This participation will include attending workgroup meetings, addressing necessary changes to local applications or databases, and cooperating with DHFS on data submission protocol and testing.

   Prior to the effective date of this contract for the year 2007, the CMO shall demonstrate it has the ability to:

   a. Analyze, integrate and report data;

   b. Capture and maintain a member level record of all services in the LTC benefit package provided to members by the CMO and its providers, in a computerized data base adequate to meet the reporting requirements of the contract;

   c. Monitor enrollment and disenrollment, in order to determine which members are enrolled or have disenrolled from the CMO on any specific day;

   d. Collect and accurately produce data, reports, and member histories including, but not limited to, member and provider characteristics, encounter data, utilization, disenrollments, solvency, member and provider appeals and grievances which satisfies the reporting requirements identified under B., *Reports: Regular Interval*, and C., *Reports: As Needed* of this Article; and,

   e. Ensure that data received from providers, and reported to DHFS, is timely, accurate and complete, by:

      i. Verifying the accuracy and timeliness of reported data;

ii. Screening the data for completeness, logic, and consistency;

iii. Collecting information on services in standardized HIPAA-compliant formats, such as the HCFA 1500 or UB92 format, or other uniform format, to the extent possible; and,

iv. Recording and tracking all services with a unique member identification number (the Medicaid ID number shall be recorded for all members who are Medicaid recipients or are eligible for the program under Family Care non-MA).

4. *Encounter Data Format*
The CMO shall report member-specific data to DHFS in an encounter-data format specified by DHFS and according to any HIPAA deadlines, standards and requirements applicable to the CMO. The specifications and HIPAA deadlines, standards and requirements are identified in documents found on the DHFS Family Care website at: https://www.wisconsinedi.org/cmoencounter/secureLogin.html. The CMO shall meet certification standards that demonstrate it has the ability to meet DHFS reporting requirements in the formats and timelines prescribed by DHFS. The CMO will provide data extracts, as necessary, for testing the reporting processes and will assist with and participate in the testing processes. The Department will provide CMOs with reasonable advance notice of required changes to encounter reporting standards, formats and MIS capacity necessary to meet federal and state requirements.

**B. Reports: Regular Interval**

The CMO agrees to furnish information from its records to DHFS, and to DHFS's authorized agents, which DHFS may require to administer this contract. See Addendum IV., *Reporting* (page 139), for a compilation of these and other reports/documents and due dates which are specified in this contract. The reports with a regular interval include, but not limited to the following:

1. *Encounter Reporting Submission*
The Encounter Reporting Submission is a monthly report. The report is due on the fifteenth of each month, or the first business day following the fifteenth when the fifteenth is not a business day. The Encounter Data Reporting Submission will be used to report member specific enrollment and disenrollment, utilization of services and expenditure in the LTC benefit package, and member characteristic/demographics. Other client specific data may be required by DHFS in the future. The Encounter Reporting Submission shall be reported on-line or through a batch methodology approved by DHFS.

2. *Financial Report*

a. The Financial Report is due as part of the Quarterly Report (described in paragraph 3, below) forty-five (45) calendar days after the close of the quarter except for the 4th quarter which is due March 31. The initial reporting period shall

begin on January 1 of the current contract year and end on the last day of March of the current contract year. All subsequent reporting periods shall be one calendar quarter for each remaining quarter of this contract or any extension of this contract. The quarterly Financial Report shall be submitted in the format provided by the Department and which contains the following components:

i. A balance sheet showing CMO assets, liabilities and equity on the last day of the quarter being reported, the previous quarter reported and the most recent December 31.

ii. An income statement showing CMO revenue, expenses and net income in dollars and PMPMs for the quarter and year to date compared to budget.

iii. Notes to the Financial Report providing sufficient detail as to the financial results, contingencies, or any other pertinent information (such as IBNR, contingent liabilities, voluntary contributions, casualty claims, etc.) as in accordance with generally accepted accounting principles.

iv. A Signed financial data certification form which is provided by DHFS per 42 CFR 438.600 and is found in Addenda VIII.

Each report must be prepared on an accrual basis and in accordance with Generally Accepted Accounting Principles. In addition, each statement must provide sufficient detailed notes to allow a determination on the part of State analysts with regard to the CMO's financial position.

b. The fourth quarter ending December 31, 2006, an "unaudited" Financial Report is also due March 31, 2007 as described above. A final "audited" year-end financial report is due on or before May 31, 2007. The audited financial report is the financial report which has been reviewed by the CMO's auditors and includes any audit adjustments and/or disclosures according to the Family Care Audit Guide. The Family Care Audit Guide is included in the Appendix to the State Single Audit Guidelines for DHFS, which can be found in the reference center at: http://www.doa.state.wi.us.

The following must be included in the final "audited" year-end financial report:

i. A financial statement as described in (a) directly above; and,

ii. Detailed "incurred but not reported" (IBNR) calculation including lags showing the post year-end run out.

3. *Quarterly Report*
The Quarterly Report is due forty-five (45) calendar days after the reporting period. DHFS may from time to time revise elements to be included in the Quarterly Report and shall give the CMO notice of new elements to include in the Report prior to the

commencement of the next reporting period. The Quarterly Report contains the following components:

a. A list of marketing materials distributed during the quarter, or proposed for development, review or reprint in the next quarter, if the CMO has an approved marketing plan and engages in marketing activities.

b. Copies of newspaper or magazine articles about the CMO that appeared during the quarter.

c. Critical incident and unexpected death aggregate data and analysis of any conclusions made by the CMO (as required in Addendum VI., *Critical Incidents Protocol*, page 155).

d. Appeal and grievance summary and log (as specified in Article IV.K. (3), *Quarterly Reports* (page 61).

e. Provider appeal log (as specified in Article V.C. (5) (e), *Appeals to the CMO and Department for Payment/Denial of Providers Claims* (page 76).

f. Financial report, and required data certification form(s), as described above in this Article under B. (2) and Addendum VIII., *Data Certification* (page 163).

g. Fraud and abuse report as specified in Article VII.J., *Program Integrity Plan, Program and Coordination* (page 97).

h. A list of any instances of provider endorsement violations encountered during the quarter, (as specified in Article V.B. (9) (w), *Prohibited Practice* (page 70).

4. *Performance Improvement Project Annual Reports*
The specifics of this report are detailed in Addendum VII., *Performance Improvement Projects* (page 159).

5. *Civil Rights Compliance Report*
The specifics of this report are detailed in Article VII.D., *Affirmative Action and Civil Rights* (page 90).

6. *Annual Audit*
The specifics of this audit are in Article VII.H., *Annual Audit* (page 95).

7. *Budget*
The specifics of this budget are detailed in Article VII.A. (2), *Budget* (page 86).

8. *CMO Quality Indicators*
The specifics regarding this data and timeframes are in Addendum II., *CMO Quality Indicators* (page 132).

**C. Reports: As Needed**

The CMO agrees to furnish reports to DHFS, and to DHFS's authorized agents, which DHFS may require to administer this contract, that are specific to certain events. Such reports include but not limited to the following:

1. *Reporting of Corporate and Other Changes*
   If corporate restructuring or any other change affects the continuing accuracy of certain information previously reported by the CMO to DHFS, the CMO shall report the change in information to DHFS.

   The CMO shall report each such change in information as soon as possible, but not later than thirty (30) calendar days after the effective date of the change. Changes in information covered under this section include all of the following:

   a. Any change in information relevant to Article VII.E., *Ineligible Organizations* (page 93).

   b. Any change in information relevant to V.B. (12) (c), *Potential Sources of Disclosure Information* (page 71).

**D. Disclosure**

The CMO and any subcontractors shall make available to DHFS, DHFS's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the CMO or subcontractors which relate to the CMO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this contract. The CMO shall comply with applicable record-keeping requirements specified in HFS 105.02(1)-(7) Wis. Adm. Code, as amended.

**E. Records Retention**

The CMO shall retain, preserve and make available upon request all records relating to the performance of its obligations under this contract, including claim forms, for a period of not less than five years from the date of termination of this contract. Records involving matters which are the subject of litigation shall be retained for a period of not less than five years following the termination of litigation. Electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHFS, provided that the electronic storage format is approved by DHFS as reliable and is supported by an effective retrieval system.

Upon expiration of the five-year retention period, the CMO may request authority from DHFS to destroy, dispose of or transfer the records identified directly above. The CMO shall retain such records until it receives written approval from DHFS.

## XI. Termination, Modification and Renewal of Contract

### A. Modification

This contract may be modified at any time by written mutual consent of the CMO and DHFS or when modifications are mandated by changes in Federal or State laws, and amendments to Wisconsin's CMS approved waivers: #0154.90.R1; #0229.90.04; #0297.02; and #0275.90. In the event that changes in State or Federal law require DHFS to modify its contract with the CMO, notice shall be made to the CMO in writing. However, the per member per month payment rate to the CMO can be modified only as provided in Article IX.C., *Renegotiation* (page 105).

If DHFS exercises the right to renew this contract, DHFS will recalculate the per member per month payment rate for succeeding calendar years. The CMO shall have sixty (60) calendar days to accept the new per member per month payment rate in writing or to initiate termination of the contract. If DHFS changes the reporting requirements during the term of this contract, the CMO shall have thirty (30) calendar days to review and comment on the fiscal impact of the additional reporting requirements. DHFS will consider any potential fiscal impact on the CMO before requiring additional reporting. It is not DHFS's intent to unilaterally impose new and previously unreimbursed requirements on the CMO. The CMO shall have 180 calendar days to comply with such changed requirements or to initiate termination of the contract.

### B. Mutual Consent of Termination

This contract may be terminated at any time by mutual written consent of both the CMO and DHFS.

### C. Unilateral Termination

This contract between the parties may be unilaterally terminated only as follows:

1. *Notice of Termination*
   This contract may be terminated by either party for any reason upon ninety (90) calendar day's written notice to the other party.

2. *Changes in Federal or State Law*
   This contract may be terminated at any time, by either party, due to modifications mandated by changes in Federal or State law, regulations, or policies that materially affect either party's rights or responsibilities under this contract. In such case, the party initiating such termination procedures must notify the other party in writing, at least ninety (90) calendar days prior to the proposed date of termination, of its intent to terminate this contract. Termination by DHFS under these circumstances shall impose an obligation upon DHFS to pay the CMO's reasonable and necessarily incurred termination expenses.

3. *Termination for Substantial Failure to Perform*
   This contract may be terminated by either party at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this contract. In such event, the party exercising this option must notify the other party, in

writing, of this intent to terminate this contract and give the other party thirty (30) calendar days to correct the identified violation, breach or non-performance of contract. If such violation, breach or non-performance of contract is not satisfactorily addressed within this time period, the exercising party must notify the other party, in writing, of its intent to terminate this contract at least ninety (90) calendar days prior to the proposed termination date. The termination date shall always be the last day of a month. The contract may be terminated by DHFS sooner than the time period specified in this paragraph if DHFS finds that member long-term care, health or welfare is jeopardized by continued enrollment in the CMO. A "substantially failed to perform" for purposes of this paragraph includes any violation of any requirement of this contract that is repeated or on-going, that goes to the essentials or purpose of the contract, or that injures, jeopardizes or threatens the long-term care, health, safety, welfare, rights or other interests of members, the CMO's failure to meet or maintain at least minimal certification or contract requirements or to make substantial progress in meeting enrollment goals in the CMO's approved enrollment plan. A violation is considered repeated and ongoing if the CMO fails to demonstrate improvement or comply with technical assistance recommendations of DHFS.

4. *Termination when Federal or State Funds Unavailable*
   This contract may be terminated by either party, in the event Federal or State funding of contractual services rendered by the CMO become or will become permanently unavailable. In the event it becomes evident State or Federal funding of claims payments or contractual services rendered by the CMO will be temporarily suspended or unavailable, DHFS shall immediately notify the CMO, in writing, identifying the basis for the anticipated unavailability or suspension of funding. Upon such notice, DHFS or the CMO may suspend performance of any or all of the CMO's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. DHFS or CMO shall attempt to give notice of suspension of performance of any or all of the CMO's obligations by sixty (60) calendar days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. In the event funding temporarily suspended or unavailable is reinstated, the CMO may remove suspension hereunder by written notice to DHFS, to be made within thirty (30) calendar days from the date the funds are reinstated. In the event the CMO elects not to reinstate services, the CMO shall give DHFS written notice of its reasons for such decision, to be made within thirty (30) calendar days from the date the funds are reinstated. The CMO shall make such decision in good faith and will provide to DHFS documentation supporting its decision. In the event of termination under this section, this contract shall terminate without termination costs to either party.

**D. Contract Non-Renewal**

The CMO or DHFS may decide to not renew this contract. In the case of a non-renewal of this contract the party deciding to not renew this contract must notify the other party in writing at least ninety (90) calendar days prior to the expiration date of this contract, and following the procedure in E. and F. in this Article.

**E. Transition Plan**

In the case of this contract being terminated or a decision to not renew this contract, the CMO shall submit a written plan that receives DHFS's approval, to ensure uninterrupted delivery of services to CMO members and their successful transition to applicable programs (e.g., Medicaid fee-for-service, Community Options Program, Community Integration Program). The plan will include provisions for the transfer of all member related information held by the CMO or its providers and not also held by DHFS.

1. *Submission of the Transition Plan*
   The CMO shall submit the plan at one of the following times, depending on which applies: no less than ninety (90) calendar days prior to the contract's expiration when the CMO decides to not renew the contract; within ten (10) business days of notice of termination by DHFS; or along with the CMO's notice of termination.

2. *Management of the Transition*
   The CMO shall designate a person responsible for coordinating the transition plan and will assign staff as DHFS determines is necessary to assist in the transition. Status meetings including staff from all parties involved in the transition will be held as frequently as DHFS determines is necessary.

3. *Continuation of Services*
   If the CMO has been unable to successfully transition all members to applicable programs by the time specified in the approved transition plan, the CMO shall continue operating as a CMO under this contract until all members are successfully transitioned. DHFS will determine when all members have been successfully transitioned to applicable programs.

   If DHFS determines it necessary to do so, the CMO will agree to extend this contract, in order to continue providing services to members until they are successfully transitioned to applicable programs. During this period the CMO remains responsible, and shall provide, the services in the LTC benefit package, and all terms and conditions of the contract will apply during this period.

**F. Obligations of Contracting Parties**

When termination or non-renewal of this contract occurs, the following obligations shall be met by the parties:

1. *Notice to Members*
   DHFS shall be responsible for developing the format for notifying all members of the date of termination and process by which the members continue to receive services in the LTC benefit package;

2. *CMO Responsibilities*
   The CMO shall be responsible for duplication, mailing and postage expenses related to said notification;

3. *Return of Advanced Payments*
   Any payments advanced to the CMO for coverage of members for periods after the date of termination or expiration shall be returned to DHFS within forty-five (45) calendar days;

4. *Transfer of Information*
   The CMO shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims; and,

5. *Recoupments*
   Recoupments will be handled through a payment by the CMO within ninety (90) calendar days of the end of this contract.

## XII. Cooperation of Parties and Dispute Resolution

### A. Agreement to Cooperate

The parties agree to fully cooperate with each other in connection with the performance of their respective obligations and covenants under this contract.

### B. Dispute Resolution

The parties shall use their best efforts to cooperatively resolve disputes and problems that arise in connection with this contract. When a dispute arises between the CMO and the DHFS that cannot be resolved, the method of resolving the dispute shall be the follow process:

1. *Disputes Involving Audits*
   For any audit dispute, review will be through the DHFS audit resolution process.

2. *Disputes Involving All Other Matters*
   For any other dispute, The CMO may request a hearing under ch. 227 Stats., with the Division of Hearings and Appeals, Department of Administration, under rules promulgated at ch. HA 1 Wis. Adm. Code. The proceeding will be conducted as a class 3 contested case.

### C. Performance of Contract Terms During Dispute

The existence of a dispute notwithstanding, both parties agree to continue without delay to carry out all their respective responsibilities which are not affected by the dispute and the CMO further agrees to abide by the interpretation of DHFS regarding the matter in dispute while the CMO seeks further review of that interpretation.

## XIII. Confidentiality of Records

The CMO agrees that all information, records, and data collected in connection with this contract shall be protected from unauthorized disclosure as provided in ch. 46 Stats., ch. HFS 108.01 Wis. Adm. Code, and 42 CFR 431 Subpart F. Except as otherwise required

by law, access to such information shall be limited by the CMO and DHFS to persons who, or agencies which, require the information in order to perform their duties related to this contract, including the U.S. Department of Health and Human Services and such others as may be required by DHFS.

The CMO shall have written confidentiality policies and procedures in regard to confidential member information. Policies and procedures must be communicated to the CMO staff, members, and providers. The transfer of member records to non-CMO providers or other agencies not affiliated with the CMO are contingent upon the receipt by the CMO of written authorization to release such records signed by the member or by the member's authorized representative.

## XIV. Documents Constituting Contract

This contract is drafted in accordance with the requirements of ss. 46.2805 to 46.2895 Stats., and ch. HFS 10 Wis. Adm. Code. The contract between the CMO and DHFS shall include, in addition to this contract and applicable provisions of the state statutes and administrative code and the CMO Contract Interpretation Bulletins issued pursuant to this contract. Each Contract Interpretation Bulletin shall be provided to the CMO for review and comment at least thirty (30) calendar days prior to its effective date. In the event of any conflict in provisions among these documents, the laws and regulations of the state and federal government shall prevail. In addition, the contract shall incorporate the following Addenda:

I. Definitions
II. CMO Quality Indicators
III. Capacity for Financial Solvency and Stability
IV. Reporting
V. Actuarial Basis
VI. Critical Incidents Protocol
VII. Performance Improvement Projects
VIII. Data Certification
IX. CMO Certification and Re-Contracting
X. Service Definitions: Family Care Benefit Package

The documents listed above constitute the entire contract between the CMO and DHFS and no other expression, whether oral or written, constitutes any part of this contract.

## XV. Miscellaneous

### A. Delegations of Authority

No delegations of authority are permitted under this contract without prior approval by DHFS.

**B. Indemnification**

1. *CMO and DHFS Liability*
   The CMO will indemnify, defend if requested and hold harmless the State and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the CMO or any of its contractors, in prosecuting work under this contract. DHFS acknowledges that the State may be required by s. 895.46 (1) Stats., to pay the cost of judgments against its officers, agents or employee, and that an officer, agent or employee of the State may incur liability due to negligence or misconduct.
2. *Pass Along Federal Penalties*

   a. The CMO shall indemnify DHFS for any federal fiscal sanction taken against DHFS or any other state agency which is attributable to action or inaction by the CMO, its officers, employees, agents or subcontractors that is contrary to the provisions of this Contract.

   b. Prior to invoking this provision, DHFS agrees to pursue any reasonable defense against the federal fiscal sanction in the available federal administrative forum. The CMO shall cooperate in that defense to the extent requested by DHFS.

   c. Upon notice of a threatened federal fiscal sanction, DHFS may withhold payments otherwise due to the CMO to the extent necessary to protect DHFS against potential federal fiscal sanction. DHFS will consider the CMO's requests regarding the timing and amount of any withholding adjustments.

**C. Independent Capacity of the CMO**

DHFS and the CMO agree that the CMO and any agents or employees of the CMO, in the performance of this contract, shall act in an independent capacity, and not as officers or employees of DHFS.

**D. Omissions**

In the event that the CMO or DHFS hereto discovers any material omission in the provisions of this contract which such party believes is essential to the successful performance of this contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this contract, or shall pursue the arbitration process available under Article XII., *Cooperation of Parties and Dispute Resolution* (page 115).

**E. Choice of Law**

This contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. The CMO shall be required to bring all legal proceedings against DHFS in the State courts in Dane County, Wisconsin.

**F. Waiver**

No delay or failure by the CMO or DHFS hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

**G. Severability**

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to members and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

**H. Force Majeure**

The CMO and DHFS shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

**I. Headings**

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

**J. Assignability**

Except as allowed under subcontracting, this contract is not assignable by the CMO either in whole or in part, without the prior written consent of DHFS.

**K. Right to Publish**

DHFS agrees to allow the CMO to write and have such writings published provided the CMO receives prior written approval from DHFS before publishing writings on subjects associated with the work under this contract. The CMO agrees to protect the privacy of individual members, as required under 42 CFR 434.6 (a) (8).

## XVI. CMO Specific Contract Terms

**County(ies) in which enrollment is accepted**: <<County>>

**Per Member Per Month Payment Rate**
The prospective payment rate shall be determined in accordance with the calculations set forth in Addendum V., *Actuarial Basis* (page 142).

Monthly per member per month payment rate for each member at the intermediate level of care: <<Intermediate Rate>>. Monthly per member per month payment rate for each member at the comprehensive level of care: <<Comprehensive Rate>>. The comprehensive rate including the ICF-MR relocation prospective adjustment is: <<Comprehensive Rate with Prospective Adjustments>>. This rate is comprised of an MA rate and a Non-MA rate. These rates are <<MA Rate) and respectively <<Non-MA Rate>>.

Monthly per member per month payment rate for each member eligible only as a "grandfather": For members who are functionally eligible through the grandfathering provision, and not functionally eligible at the comprehensive or intermediate level of care, the CMO will be paid the actual cost of the care plan services, except for case management services, during the sixty (60) calendar days before the Family Care benefit became available in the CMO county. The CMO shall receive an additional $50.00 per month for case management for each grandfathered enrollee. The total will be paid to the CMO on a prospective basis. (See the definition of "eligibility" in Addendum I., *Definitions*, beginning page 120, regarding the grandfathering provision). Persons eligible for Family Care under this grandfather provision are entitled to all the benefits and rights of membership in the CMO and all contract provisions apply equally to them.

THIS CONTRACT SHALL BECOME EFFECTIVE ON JANUARY 1, 2007, AND SHALL EXPIRE ON DECEMBER 31, 2007, UNLESS TERMINATED EARLIER.

In WITNESS WHEREOF, the State of Wisconsin and <<Generic>> County have executed this contract:

| FOR CMO: | FOR STATE: |
|---|---|
| BY: <<Signature>>, <<Title>><br><<Department>><br><<Generic>> County | BY: Sinikka Santala, Administrator<br>Division of Disability and Elder Services<br>Dept. of Health & Family Services |
| DATE | DATE |

## Addenda

## I. Definitions

(1) "Abuse" means any of the following, if done intentionally, negligently or recklessly:

a) An act, omission or course of conduct by another that is not reasonably necessary for treatment or maintenance of order and discipline and that does at least one of the following:

- Results in bodily harm or great bodily harm to an enrollee.
- Intimidates, humiliates, threatens, frightens or otherwise harasses an enrollee.

b) The forcible administration of medication or treatment with the knowledge that no lawful authority exists for the administration or performance.

(2) "Activities of daily living" or "ADLs" means bathing, dressing, eating, mobility, transferring from one surface to another such as bed to chair and using the toilet.

(3) "Adult family home" or "AFH" has the meaning specified in s. 50.01 (1) Stats.

(4) "Adult protective services" means protective services for mentally retarded and other developmentally disabled persons, for aged infirm persons, for chronically mentally ill persons and for persons with other like incapacities incurred at any age as defined in s. 55.02 Stats.

(5) Advance Directive—a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated.

(6) "Assets" means any interest in real or personal property that can be used for support and maintenance. "Assets" includes motor vehicles, cash on hand, amounts in checking and savings accounts, certificates of deposit, money market accounts, marketable securities, other financial instruments and cash value of life insurance.

(7) "Assistance" means cueing, supervision or partial or complete hands-on assistance from another person.

(8) "At risk of losing independence or functional capacity" means having the conditions or needs described in ch. HFS 10.33 (4) (b) Wis. Adm. Code.

(9) "Care management organization" or "CMO" means an entity that is certified as meeting the requirements for a care management organization under s. 46.284 (3) Stats., and, has a contract under s. 46.284 (2) Stats., and ch. HFS 10.42 Wis. Adm. Code. "Care management organization" does not include an entity that contracts with DHFS to operate a PACE or Wisconsin partnership program.

(10) "Case Management" means assessment, care planning, assistance in arranging and coordinating services in the care plan, assistance in filing complaints and grievances and obtaining advocacy services, and periodic reassessment and updates of the person's care plan.

(11) Cash Reserve—a segregated fund account that the CMO establishes to ensure continuity of care for its members, accountability to taxpayers, solvency protection against financially catastrophic cases, and effective program administration.

(12) Center for Medicare and Medicaid Services (CMS)—The Federal agency, formerly known as "Health Care Finance Administration" (HCFA), responsible for oversight and federal administration of Medicare and Medicaid programs.

(13) "Client" means a person applying for eligibility for the Family Care benefit, an eligible person or an enrollee.

(14) "Client Rights" means rights in Family Care outlined in applicant information materials and the member handbook as approved by DHFS consistent with HFS 10.51.

(15) "Conflict of Interest" means a situation where a person or entity other than the member is involved in planning or delivery of services to the member, and has an interest in, or the potential to benefit from, a particular decision, outcome or expenditure.

(16) "Community-based residential facility" or "CBRF" has the meaning specified in s. 50.01 (1g) Stats. Except that utilization of CBRFs in Family Care shall comply with the following:

a) There are no bed size limits for elderly and people with physical disabilities who enroll in a Family Care CMO.

b) CMOs may not serve members who are developmentally disabled in a CBRF with more than eight (8) beds, except if the person resided in a CBRF larger than eight (8) beds funded by COP or Community Aids prior to enrolling in the CMO and has made an informed choice to remain. This must be documented as follows:

- The CMO shall produce a list and maintain a list of all persons with a developmental disability who, on the effective date of the CMO's first HCS Contract resided and received services funded by county COP or Community Aids in CBRFs larger than 8 beds, and,

- The interdisciplinary team records in the member's individual service plan that during the first year after enrollment the member has been shown and offered the option of at least one smaller CBRF (eight (8) beds or less), but has chosen not to relocate.

(17) "Community spouse" means an individual who is legally married as recognized under state law to a Family Care spouse.

(18) "Complaint" means any communication made to DHFS, a resource center, a care management organization or a service provider by or on behalf of a client expressing dissatisfaction with any aspect of the operations, activities or behaviors of DHFS, resource center, care management organization or service provider related to access to or delivery of the Family Care benefit, regardless of whether the communication requests any remedial action.

(19) Contract/This Contract/Health and Community Supports Contract—this contractual agreement between DHFS of Health and Family Services and the CMO and its addenda, which is a Pre-Paid Health Plan (PHP).

(20) "Countable assets" means assets that are used in calculating financial eligibility and cost sharing requirements for the Family Care benefit.

(21) "County agency" means a county department of aging, social services or human services, an aging and disability resource center, a Family Care district or a tribal agency, that has been designated by DHFS to determine financial eligibility and cost sharing requirements for the Family Care benefit.

(22) "Crime" means conduct which is prohibited by state law and punishable by fine or imprisonment or both. Conduct punishable only by a forfeiture is not a crime.

(23) "Critical Incident" means an event, incident, or course of action or inaction that is either "unexpected" or that is the result of alleged "abuse", "neglect", or other "crime", or a violation of "client rights, and that results in:

a) Harm to health, safety and well being of an enrollee or another person; or,

b) Substantial loss in the value of the personal or real property of an enrollee or another person.

(24) Days—unless otherwise specified in the contract (e.g., "calendar days"), days shall mean business days.

(25) "Developmental disability" means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, that has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. "Developmental disability" does not include senility that is primarily caused by the process of aging or the infirmities of aging.

(26) "DHFS" means the Wisconsin Department of Health and Family Services.

(27) "Economic Support Specialist" (also known as Income Maintenance (IM) worker) means "a person employed by a county or a governing body of a federally recognized American Indian tribe whose duties include determinations or re-determinations of IM program eligibility, including financial eligibility for Medicaid, the Family Care program and other public benefits."

(28) Eligibility/Eligible Person – A person is eligible for membership in the CMO if the person meets all eligibility requirements defined in ss. 46.286 (1) and (2) Stats., and chs. HFS 10.32 and 10.34 Wis. Adm. Code. Eligibility is determined by the resource center and economic support unit prior to enrollment in the CMO or upon recertification of eligibility by the resource center and economic support unit. CMOs verify eligibility through the MMIS systems. Providers verify eligibility through the Automated Voice Response (AVR) system or through an eligibility verification vendor.

(29) "Encounter Reporting" means the collection and reporting of encounter data to the Department of Health and Family Services. Encounter data are detailed records of health care services or items that have been provided to CMO members. Encounter data are used for rate setting and program analysis.

(30) "Enrollee" means a person who is enrolled in a care management organization to receive the Family Care benefit.

(31) "Enrollment Consultant" means an individual who performs enrollment consulting activities to potential enrollees such as, as answering questions and providing information in an unbiased manner on available delivery system options, including the option of enrolling in a CMO or a PACE/Partnership organization, and advising on what factors to consider when choosing among these options.

(32) "Fair hearing" means a de novo proceeding under ch. HA 3 Wis. Adm. Code, before an impartial administrative law judge in which the petitioner or the petitioner's representative presents the reasons why an action or inaction by DHFS, a county agency, a resource center or a CMO in the petitioner's case should be corrected.

(33) "Family Care benefit" has the meaning given in s. 46.2805 (4) Stats., namely, financial assistance for long-term care and support items for an enrollee.

(34) "Family Care district" means a special purpose district created under s. 46.2895 (1) Stats.

(35) "Family Care spouse" means an individual who is a Family Care applicant or enrollee and is legally married as recognized under state law to an individual who does not reside in a medical institution or a nursing facility.

(36) "Financial eligibility and cost-sharing screen" means a uniform screening tool prescribed by DHFS that is used to determine financial eligibility and cost-sharing under ss. 46.286 (1) (b) and (2) Stats., and chs. HFS 10.32 and 10.34 Wis. Adm. Code.

(37) "Fraud" means an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to him/herself, itself or to some other person or entity. It includes any act that constitutes fraud under applicable Federal or State law.

(38) "Functional capacity" means the skill to perform activities in an acceptable manner.

(39) "Functional screen" means a uniform screening tool prescribed by DHFS that is used to determine functional eligibility under ss. 46.286 (1) (a) and (1m) Stats., and chs. HFS 10.32 and 10.33 Wis. Adm. Code.

(40) "Gift" means something of value voluntarily transferred by one person or entity to another person or entity without compensation.

a) "Something of value" means cash or some other exiting identifiable thing that has a fair market value of more than $10.00.

b) "Voluntarily transferred" means:

- The person or entity transferring the thing of value has the intention to voluntarily give it without compensation; and,
- The person transferring the gift is competent (in order to have intention); and,
- The person or entity receiving the gift is an eligible recipient (e.g., some entities have prohibitions against employees accepting gifts); and,
- The thing of value is an existing identifiable thing (e.g., a promise to give something in the future is not a gift); and,
- The thing of value is actually transferred.

(41) "Grandfather" means a person who meets Family Care grandfathering eligibility criteria. Grandfathering applies only to functional eligibility in Family Care. It does

not apply to Family Care target group or financial eligibility. To be eligible for Family Care, a person who is grandfathered must still be a member of a Family Care target group and meet financial and other eligibility requirements. A person may be grandfathered for Family Care functional eligibility at any time he/she meets all of the following conditions. The person:

a) Has a condition that is expected to last at least ninety (90) days or result in death within twelve (12) months.

b) First applies for eligibility for the Family Care benefit within thirty-six (36) months after the date on which the Family Care benefit is initially available in the person's county of residence.

c) Does not currently meet either the comprehensive or intermediate level of care.

d) Was, on the date Family Care became available in his/her county of residence, either: (1) A resident in a nursing home; or (2) A recipient, under a written plan of care for at least the past sixty (60) days, of services funded under COP, a HCBS waiver, AFCSP, or Community Aids or other county funding if documented under a method prescribed by the Department.

(42) "Home" means a place of abode and lands used or operated in connection with the place of abode.

(43) "Hospital" has the meaning specified in s. 50.33 (2) Stats.

(44) Ineligibility/Ineligible Person—a person is ineligible for membership in the CMO if the person fails to meet all eligibility requirements as determined by the resource center or economic support unit prior to enrollment in the CMO, or if the person determined to be eligible prior to enrollment no longer meets eligibility requirements as determined by the resource center or economic support unit.

(45) "Infirmities of aging" has the meaning given in s. 55.01 (3) Stats., namely, organic brain damage caused by advanced age or other physical degeneration in connection therewith to the extent that the person so afflicted is substantially impaired in his or her ability to adequately provide for his or her care or custody.

(46) "Instrumental activities of daily living" or "IADLs" means management of medications and treatments, meal preparation and nutrition, money management, using the telephone, arranging and using transportation and the ability to function at a job site.

(47) "Local long-term care council" means a council appointed under s. 46.282 (2) Stats.

(48) Long-Term Care Benefit Package/LTC Benefit Package—services provided by the CMO directly or through other providers for which DHFS makes a per member per month payment to the CMO.

(49) "Long-term care facility" means a nursing home, adult family home, community-based residential facility or residential care apartment complex.

(50) "Long-Term Care Outcome" means a desirable situation, condition, or circumstance of a member's life that can be a result of effective long-term care. Long-term care outcomes include three types of outcomes:

a) "Clinical outcome" means a condition or circumstance that relates to a member's individual physical, mental, or emotional health, safety, or well-being. Clinical outcomes are objectively measurable by someone other than the member, and their presence or absence can be determined without knowing the member's personal preferences regarding the condition or circumstance.

b) "Functional outcome" means an ability that the member has or does not have to perform certain functions, tasks, or activities. The presence, absence, or degree of functional outcomes can be objectively measurable by someone other than the member, and their presence or absence can be determined without knowing the member's personal preferences regarding the functional ability.

c) "Personal-experience outcome" means one of the 12 outcomes listed in Addendum VII, Part 2. The presence, absence, or degree to which a personal-experience outcome is present in any member's life can be determined only by ascertaining the member's individual preference with regard to the outcome and by ascertaining the member's assessment of whether that desired circumstance is present for him/her.

(51) Marketing/Outreach Activities—the production and dissemination of marketing/outreach materials and the sponsorship of community events that can be reasonably interpreted as intended to influence individuals to enroll or reenroll in the CMO.

(52) Marketing/Outreach Materials—materials in all mediums, including but not limited to, internet, brochures and leaflets, newspaper, magazine, radio, television, billboards, yellow pages, advertisements, other print media and presentation materials, used by or on behalf of the CMO to communicate with individuals who are not members, and that can be reasonably interpreted as intended to influence the individuals to enroll or reenroll in the CMO.

(53) Medicaid, the Wisconsin Medical Assistance program operated by the Wisconsin Department of Health and Family Services under Title XIX of the Federal Social Security Act, ch. 49 Stats., and related State and Federal rules and regulations. The term "Medicaid" will be used consistently in the contract. However, "Medicaid" is also known as "MA," "Medical Assistance," and "WMAP."

(54) "Medical institution" means a facility that meets all of the following conditions:

a) Is organized to provide medical care, including nursing and convalescent care.

b) Has the necessary professional personnel, equipment and facilities to manage the medical, nursing and other health care needs of patients on a continuing basis in accordance with accepted professional standards.

c) Is authorized under state law to provide medical care.

d) Is staffed by professional personnel who are responsible for professional medical and nursing services. The professional medical and nursing services include adequate and continual medical care and supervision by a physician, registered nurse or licensed practical nurse supervision and services and nurses' aide services sufficient to meet nursing care needs and a physician's guidance on the professional aspects of operating the institution.

(55) Medically Necessary Services—are Medicaid services (as defined under s. 49.46 Stats., and ch. 107 Wis. Adm. Code) that are required to prevent, identify or treat a member's illness, injury or disability; and that meet the following standards:

a) Is consistent with the member's symptoms or with prevention, diagnoses or treatment of the member's illness, injury or disability;

b) Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

c) Is appropriate with regard to generally accepted standards of medical practice;

d) Is not medically contraindicated with regard to the member's diagnoses, symptom, or other medically necessary services being provided to the member;

e) Is of proven medical value or usefulness and, consistent with ch. HSS 107.035 Wis. Adm. Code, is not experimental in nature;

f) Is not duplicative with respect to other services being provided to the member;

g) Is not solely for the convenience of the member, the member's family or a provider;

h) With respect to prior authorization of a service and other prospective coverage determinations made by DHFS, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member; and,

i) Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

(56) Member—a person who meets the eligibility criteria and has signed an Enrollment Request.

(57) Necessary Long-Term Care Services and Supports—include any service or support that is provided to assist a member complete daily living activities, learn new skills, maintain a general sense of safety and well-being, or otherwise pursue a normal daily life rhythm, and that meets the following standards:

a) Is consistent with the member's comprehensive assessment and Individual Service Plan;

b) Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

c) Is appropriate with regard to Department's and CMO's generally accepted standards of long-term care and support;

d) Is not duplicative with respect to other services being provided to the member;

e) With respect to prior authorization of a service and other prospective coverage determinations made by the CMO, is cost-effective compared to an alternative necessary long-term care service which is reasonably accessible to the member; and,

f) Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

(58) "Neglect" means an act, omission or course of conduct by another that, because of the failure to provide adequate food, shelter, clothing, medical care or dental care, creates a significant danger to the physical or mental health of an enrollee.

(59) "Nursing home" has the meaning specified in s. 50.01 (3) Stats.

(60) "Older person" means a person who is at least 65 years of age.

(61) "PACE" means a program of all-inclusive care for the elderly authorized under 42 USC 1395 to 1395gg.

(62) "Physical abuse" means the willful or reckless infliction of bodily harm. Bodily harm means physical pain or injury, illness, or any impairment of physical condition.

(63) "Physical disability" means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person. In the context of physical disability, "major life activity" means self-care, performance of manual tasks unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking and capacity for independent living.

(64) "Private pay individual" means any of the following:

a) A person who is a member of a CMO's target population and who does not qualify financially for the Family Care benefit under ch. HFS 10.34 Wis. Adm. Code.

b) A person who is eligible for the Family Care benefit under ch. HFS 10.32 Wis. Adm. Code, but who is not entitled to receive the benefit immediately as specified in ch. HFS 10.36 (3) Wis. Adm. Code.

c) A person who meets the entitlement conditions specified in ch. HFS 10.36 (1) Wis. Adm. Code, but who is waiting for enrollment in a CMO under the phase-in provisions of ch. HFS 10.36 (2) Wis. Adm. Code.

(65) "Purchase of enhanced services" – Member or family choice to purchase at fair market value, a service from the CMO, a CMO provider or any individual agency associated with the CMO or its providers either:

a) Not included in the Family Care benefit package and, for Medicaid-eligible members, not covered by Medicaid; or,

b) Additional services included in the Family Care benefit that are not necessary to achieve member outcomes as agreed upon by the CMO and the member (as documented in the Member-Centered Plan and Individual Service Plan (ISP) or MCP/ISP.

(66) Recipient—any individual entitled to benefits under Title XIX of the Social Security Act, and under the Medicaid State Plan as defined in ch. 49 Stats.

(67) "Residential care apartment complex" or "RCAC" has the meaning specified in s. 50.01 (1d) Stats.

(68) "Resource center" or "aging and disability resource center" means an entity that meets the standards for operation and is under contract with DHFS to provide services under s. 46.283 (3) Stats., or, if under contract to provide a portion of the services specified under s. 46.283 (3) Stats., meets the standards for operation with respect to those services.

(69) "Respite care" means temporary placement in a long-term care facility for maintenance of care, treatment or services, as established by the person's primary care provider, in addition to room and board, for no more than 28 consecutive calendar days at a time.

(70) "Secretary" means the secretary of DHFS.

(71) Service Area— the geographic area within which potential members must reside in order to enroll and remain enrolled in the CMO under this contract. Potential members shall be residents of the county (or one of the counties) listed in Article XVI., *CMO Specific Contract Terms* (page 119).

(72) Services Necessary to Achieve Outcomes—services necessary to achieve outcomes identified in the member's Individual Service Plan include both "necessary long-term care services" and "medically necessary services." The CMO can offer reasonable alternative services that meet a member's needs and desired outcomes at less expense. Reasonable alternatives are those which:

a) Have been effective for persons with similar needs; and,

b) Would not have significant negative impact on desired outcomes.

(73) "Sexual abuse" means sexual conduct in the first through fourth degrees as defined in s. 940.225 Stats.

(74) Subcontract—any written agreement between the CMO and another party for services in the LTC benefit package, and other products and services provided to the CMO.

(75) Subcontractor/CMO Provider—a service provider the CMO has an agreement with for providing services to CMO's members. "Applicant" means a person who directly or through a representative makes application for the Family Care benefit.

(76) "Target population" means any of the following groups that a resource center or a care management organization has contracted with DHFS to serve:

a) Older persons.

b) Persons with a physical disability.

c) Persons with a developmental disability.

(77) "Unexpected" means an event or incident that occurs without warning, and was not anticipated or considered probable.

(78) "Voluntary Contributions, Payments or Repayments" – Member choice to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible,

reduce potential claim in an estate, or in gratitude for Medicaid services that were provided. The payment is made to the State Medicaid program. A member cannot pay more than what Medicaid has paid for that individual.

## II. CMO Quality Indicators

This addendum lists the quality indicators the CMO will report directly to the Department. These indicators will help highlight areas for improvement in service delivery and program management by the CMOs. Results from the first year of reporting will be used to help set standards and benchmarks, where appropriate, and to analyze the validity of this data as quality indicators. The Department has not yet defined the minimum standard(s) CMOs need to reach, and has not yet finalized the set of indicators that will be used to measure quality.

The purpose of including these indicators in the contract is to communicate to the CMO specific areas the Department will be monitoring, and indicate which areas the CMO will need to collect information for the Department.

| Focus Area | Self Determination & Rights |
|---|---|
| **Consumer Outcome** | • People choose their services.<br>• People choose their daily routine. |
| **Quality Indicator** | Percent of members choosing some level of self-directed supports. (Risk adjustment issues should be considered with this indicator.) |
| **Population Groupings** | Stratify by target population and age. |
| **Performance Measure** | Numerator: Number of members using fiscal agency or co-employment agency at any time during contract period.<br>Denominator: Total number of members enrolled at any time during the contract period. |
| **Data Source** | CMO data. |
| **Data Elements** | Client demographics, program eligibility date, service. |
| **Timeframe** | Contract period. |
| **Reporting Requirements** | CMO: To be determined. |

| Focus Area | Health & Safety |
|---|---|
| **Consumer Outcome** | People experience continuity and security. |
| **Quality Indicator** | Percent of social service coordinators and percent of RNs who separated during the contract period (i.e., turnover rate). Separation is defined as movement out of an organization (i.e., it includes resignations as well as terminations). Separations do not include transfers, promotions within an organization, temporary hires (LTEs). |
| **Population Grouping** | None. (Interdisciplinary team members are reported by provider type, i.e., social service coordinator, registered nurse). |

| | |
|---|---|
| **Performance Measure** | Numerator 1: Number of case managers in the denominator who separated during the reporting year, i.e., who were not employed by the CMO as of December 31 of the reporting period (the numerator should include all interdisciplinary team members regardless of why they separated, e.g., retired, etc.).<br>Denominator 1: The total number of case managers employed by the CMO as of December 31 of the year preceding the reporting year. Do not count the number of positions, e.g., if three different persons were employed in a particular position during the year, all three would be counted as part of the total number of interdisciplinary team members. There are no exclusions from the denominator, i.e., all providers should be included whether they died, retired, were terminated or relocated during the reporting year.<br>Numerator 2: Number of RNs in the denominator who separated during the reporting year, i.e., who were not employed by the CMO as of December 31 of the reporting period (the numerator should include all interdisciplinary team members regardless of why they separated, e.g., retired, etc.).<br>Denominator 2: The total number of RNs employed by the CMO as of December 31 of the year preceding the reporting year. Do not count the number of positions, e.g., if three different persons were employed in a particular position during the year, all three would be counted as part of the total number of interdisciplinary team members. There are no exclusions from the denominator, i.e., all providers should be included whether they died, retired, were terminated or relocated during the reporting year. |
| **Data Source** | CMO administrative data. |
| **Data Elements** | Provider type (CM or RN), total number of staff, total number of separated, percent separated. |
| **Timeframe** | Contract period. |
| **Reporting Elements** | CMO: Provide turnover data by March 1, 2008. |

| **Focus Area** | **Health & Safety** |
|---|---|
| **Consumer Outcome** | People have the best possible health. |
| **Quality Indicator** | Percent of CMO members who received an influenza vaccine during the measurement time period and who were members of the CMO during the measurement period. |
| **Population Grouping** | By target group. |

| | |
|---|---|
| **Performance Measure** | Numerator: Number of CMO members in the denominator whose service record contains documentation that an influenza vaccine was administered during the reporting period.<br>Denominator: The number of members continuously enrolled through the measurement time period. (Measurement time period is September 1, 2007 to December 31, 2007.) |
| **Data Source** | CMO service records. |
| **Data Elements** | Member name, Medicaid ID #, DOB, and sex. |
| **Timeframe** | Contract period. |
| **Reporting Requirements** | CMO: Provide immunization data report by March 1, 2008. |

| **Focus Area** | **Health & Safety** |
|---|---|
| **Consumer Outcome** | People have the best possible health. |
| **Quality Indicator** | Percent of CMO members who received a pneumovax vaccine in last ten years. |
| **Population Grouping** | By target group. |
| **Performance Measure** | Numerator: Number of CMO members in the denominator whose service record contains documentation of having had a pneumovax vaccine within the last ten years. (Exception: for those members aged 65 or older, one vaccine administered at >= 65 years of age will count as a numerator event.).<br>Denominator: The number of members continuously enrolled for at least six (6) months July 1, 2007 to December 31, 2007. |
| **Data Source** | CMO service records |
| **Data Elements** | Member name, Medicaid ID #, age, sex and target population. |
| **Timeframe** | Contract period. |
| **Reporting Requirements** | CMO: Provide indicator data by March 1, 2008. |

## III. Capacity for Financial Solvency and Stability

Prior to the effective date of this contract, the CMO must meet the standards for certification set forth in Administrative Rule HFS 10.43 (4) (a) Wis. Adm. Code, requiring that the CMO shall demonstrate the capacity for financial solvency and stability and the ability to assume the level of financial risk required under this contract. Components necessary to demonstrate organizational fiscal capacity shall include: adequate working capital as set forth in section A of this addendum, restricted reserve as set forth in section B of this addendum and solvency and termination requirements as set forth in section C of this addendum. For purposes of this addendum capitation payment will mean all payments by DHFS to the CMO to provide services in the LTC Benefit Package to the CMO's members. During the term of this contract the CMO shall establish a separate and distinct fund within the county structure exclusively for operation of the CMO on an accrual basis of accounting.

### A. Working Capital

1. *Purpose.* The purpose of working capital is to provide ongoing liquid assets to manage routine fluctuations in revenue and expenses that will occur in the day to day normal course of business operations.

2. *Working Capital Calculation and Minimum Balance.* Working capital shall be an amount calculated by the CMO, and agreed to by DHFS, that is the difference between current assets and current liabilities, but shall be maintained at a level not less than 2% of the budgeted annual capitation payments from DHFS to the CMO for the period of this contract.

3. *Reports.* The CMO shall include a calculation of the current working capital compared to the required working capital as part of the quarterly financial reports.

4. *Failure to Maintain Required Minimum Balance.* In the event the CMO fails to maintain and report adequate working capital for a quarter, the CMO shall submit monthly financial statements until the deficiency has been corrected. In the event that the CMO fails to maintain and report adequate working capital for three consecutive months, the CMO shall submit a corrective action plan for DHFS approval which shall at a minimum include analysis of the reasons for the shortfall and a plan for restoring an adequate working capital balance. If the CMO continues to maintain inadequate working capital, DHFS may impose any sanctions consistent with Article VIII.K., *Remedies for Violation, Breach, or Non-Performance of Contract,* (page 100) or terminate the contract in accordance with Article XI.C., *Unilateral Termination* (page 112).

### B. Restricted Reserve

1. *Purpose.* The purpose of the restricted reserve is to provide continuity of care for enrolled members, accountability to taxpayers, and effective program administration including the ability to manage the operation of the CMO as a

separate and distinct fund with adequate liquid assets to manage volatility of the program.

2. *Restricted Reserve Funds.* The CMO shall establish and maintain a separately identifiable restricted investment reserve account in a financial institution.

3. *Required Contributions*. The requirements under this subsection apply during the period of this contract to any CMO.

   a. *Initial Balance.* Prior to the effective date of this contract, the CMO shall have a minimum balance that is the greater of $250,000 or 50% of the amount calculated under (d) of this subsection in the restricted reserve fund account.

   b. *Contribution.* The CMO shall deposit an amount that will provide not less than the minimum balance required under (d) of this subsection, *Required Minimum Balance*.

   c. *Earnings.* Any income or gains generated by the restricted reserve funds are to remain within the account until the CMO meets the required minimum balance as set forth in subsection (d) *Required Minimum Balance* immediately below.

   d. *Required Minimum Balance.* The minimum balance is an amount set for the term of each contract which is based on the budgeted annual capitation payment as projected by the CMO and approved by DHFS. The required minimum balance is calculated as follows:

      - 8% of the first $5 million of budgeted annual capitation
      - 5% of the next $5million of budgeted annual capitation
      - 3% of the next $10 million of budgeted annual capitation
      - 2% of the next $30 million of budgeted annual capitation
      - 1% of any additional budgeted annual capitation to a maximum required minimum balance of $2 million.

   e. The CMO shall attain required minimum balance on or before the beginning of the contract year that is 100% of the amount as calculated using the formula immediately above.

4. *Disbursements.* Once the minimum balance is met or when DHFS allows, disbursements may be made from the restricted reserve account in order to fund payments for operating expenses, or for any other purpose approved by DHFS. For any withdrawals or disbursements that are made, the following requirements apply:

a. *Disbursement Notifications*. The CMO must first obtain DHFS approval for withdrawals or disbursements, if the withdrawal or disbursement results in a balance below the required minimum balance. DHFS shall approve requests only after consideration of all solvency protections available to the CMO. Withdrawals or disbursements that result in an account balance below the required minimum balance will only be approved for the working capital or operating expenses of the CMO.

b. *Plans for Replenishing Restricted Reserve When Below Minimum*. The CMO shall have a plan, approved by DHFS in its sole discretion, which specifies the methods and timetable the CMO shall employ to replenish the restricted reserve fund if below the minimum balance. Failure to submit an acceptable plan to DHFS may subject the CMO to the remedies specified in Article VIII.K., *Remedies for Violation, Breach, or Non-Performance of Contract* (page 100). In approving or disapproving the plan, DHFS will take into account existing or additional solvency protections available to the CMO.

5. *Reporting.* The CMO shall report on the status of the restricted reserve account as part of the quarterly financial report required under this contract.

6. *Failure to Maintain Required Minimum Balance.* In the event the CMO fails to maintain and report adequate restricted reserve, DHFS may impose any sanctions consistent with Article VIII.K., *Remedies for Violation, Breach, or Non-Performance of Contract* (page 100) or terminate the contract in accordance with Article XI.C., *Unilateral Termination* (page 112).

## C. Solvency and Termination Requirements

1. *General Requirements.* In the event that the CMO has budgeted annual capitation payments in excess of $10,000,000, on or before the effective date of this contract, the CMO shall provide evidence of solvency protections through means acceptable to DHFS, including without limitation, county guarantee or contribution to an individual solvency fund. Except as agreed upon between the parties, the CMO shall retain solvency protection for the term of this contract consistent with the means acceptable to DHFS on the effective date of this contract. The CMO shall inform DHFS of any change or anticipated change to the solvency protections of the CMO, or any events or occurrences likely to affect the CMO's solvency, as soon as possible but no later than ten (10) business days after the CMO becomes aware of such changes, events or occurrences.

2. *Solvency Options.* The CMO shall demonstrate financial solvency and the ability to assume the level of financial risk required under this contract. If the CMO is operated by a county or county agency, the following requirements apply:

a. *County Guarantee.* The county guarantees that the county is responsible for all financial obligations of the CMO. The county shall establish a separately

identifiable reserve account in the amount of $250,000 for any CMO with budgeted annual capitation payments in excess of $10,000,000, restricted for use in the event the CMO becomes insolvent. The insolvency account ensures the availability of immediate liquid assets to assure continuity of care during any time necessary for the county to develop funds necessary to meet all obligations of the CMO.

3. *Distribution*. Upon termination DHFS shall disburse funds in the pledged insolvency account or funds held by the CMO in accordance with the county guarantee in the following order:

    - To satisfy outstanding expenses of the CMO for services authorized and provided to members of the CMO;

    - To pay for the costs of Temporary Management appointed in accordance with Article VIII.K. (6), *Appointment of Temporary Management* (page 104);

    - To satisfy outstanding administrative expenses provided under contract with the CMO by a vendor owned and operated by an entity other than the CMO;

    - To satisfy outstanding claims by the state or federal government for recoupment;

    - To pay for the costs associated with the transition of members following disenrollment;

    - To pay for internal expenses of the CMO including wages, salaries and other compensation of administrative and program staff; and,

    - To the CMO.

4. *Failure to Maintain Required Minimum Balance.* In the event the CMO fails to maintain and report adequate solvency protection, DHFS may impose any sanctions consistent with VIII.K., *Remedies for Violation, Breach, or Non-Performance of Contract* (page 100) or terminate the contract in accordance with Article XI.C., *Unilateral Termination* (page 112).

## IV. Reporting

**During the Course of This Contract**: The following tables are provided for information only. Due dates indicated in the table are based upon reporting requirements as set forth in the 2006 contract and as listed in this contract in Article X.B., page 108.

### Reports Required in the 2006 Health and Community Supports Contract but due in 2007

| Report | Reporting Period | Due Date |
|---|---|---|
| Encounter Reporting Submission | December 2006 | Jan 15, 2007 |
| Quarterly Report (with Financial Report) | 4th Quarter 2006 | Feb 15, 2007 |
| Quality Indicators Report | CY 2006 | March 1, 2007 |
| Audited Year-End Financial Report | CY 2006 | May 31, 2007 |

# Reports Required in 2007

| Report | Reporting Period | Due Date | Submit To | Contract Reference |
|---|---|---|---|---|
| **Encounter Reporting Submission And Data Certification Forms As Applicable** | January 2007 | February 15, 2007 | Submit via the DHFS Encounter Reporting website at: https://www.wisconsinedi.org/cmoencounter/secureLogin.html | Article X.B. (1) |
| | February 2007 | March 15, 2007 | | |
| | March 2007 | April 16, 2007 | | |
| | April 2007 | May 15, 2007 | | |
| | May 2007 | June 15, 2007 | | |
| | June 2007 | July 16, 2007 | | |
| | July 2007 | August 15, 2007 | | |
| | August 2007 | September 17, 2007 | | |
| | September 2007 | October 15, 20067 | | |
| | October 2007 | November 15, 2007 | | |
| | November 2007 | December 17, 2007 | | |
| | December 2007 | January 15, 2008 | | |
| | | | | |
| **Quarterly Report** (Includes Financial Report) and **Financial Data Certification Forms As Applicable** | 1st Quarter 2007 | May 15, 2007 | DHFS-DDES-BLTS CMO Contracts Section cmoteam@dhfs.state.wi.us | Article X.B. (3) |
| | 2nd Quarter 2007 | August 15, 2007 | | |
| | 3rd Quarter 2007 | November 15, 2007 | | |
| | 4th Quarter 2007 | February 15, 2008 | | |
| | | | | |
| **Final "Audited" Year-End Financial Report** | 2007 Year-End Report | May 31, 2008 | DHFS-DDES-BLTS CMO Contracts Section cmoteam@dhfs.state.wi.us | Article X.B. (2) |
| | | | | |
| **Performance Improvement Project Report** | 2006-07 Annual Report (7/1/06 - 6/30/07) | In conjunction with the annual quality review. | MetaStar, Inc. Attention: Kris Hoffman khoffman@metastar.com | Addendum VII |
| | 2007-08 Annual Report (7/1/07 - 6/30/08) | In conjunction with the annual quality review. | | |
| | | | | |
| **Quality Indicators Report** | 2007 | March 1, 2008 | MetaStar, Inc. Attention: Family Care Quality Indicators https://www.metastar.com/support/transfer/ | Addendum II |

| Report | Reporting Period | Due Date | Submit To | Contract Reference |
|---|---|---|---|---|
| **Updated Three-Year Enrollment Plan** | January 1, 2007 through December 31, 2010 | March 1, 2007 | DHFS-DDES-BLTS<br>CMO Contracts Section<br>cmoteam@dhfs.state.wi.us | Article VII.A. (2) (a) |
| | January 1, 2007 through December 31, 2010 | September 1, 2007 | | |

## V. Actuarial Basis

The per member per month capitation rates for this contract were developed by DHFS in conjunction with PricewaterhouseCoopers, LLP (PWC), Actuaries and Consultants. This addendum presents a summary of the major steps in the rate setting process. The actuarial detail for the calculation of these rates can be found in the document "Family Care Capitation Rates, CY 2007."

### A. Comprehensive MA Gross Rate

1. The comprehensive rates are calculated in eight main steps. While a separate rate calculation is carried out for each Family Care CMO, some of these steps are carried out at an aggregate, program-wide level. The eight steps are as follows:

    a. Identify functional status measures from the Wisconsin Long-Term Care Functional Screen that are predictive of long-term care service costs within the managed care environment;

    b. Match members' monthly 2005 costs with their monthly long-term care functional screens, and use statistical techniques to determine the specific dollar amount associated with each functional status indicator in CY 2005;

    c. Establish the August, 2006, case mix across the relevant functional status indicators for each individual CMO;

    d. Weight each of the specific dollar impacts identified in step b with the case mix proportions established in step c, not to exceed the all-county base PMPM 2005 costs;

    e. Apply a CMO-specific geographic factor;

    f. Trend forward the 2005 dollar amounts to CY 2007;

    g. Add an administrative allowance; and,

    h. Add a risk margin. The risk margin better fits rates to the known risks of CMOs. The risk margin is weighted by CMO size.

2. In CY 2007, an adjustment for provider rate increases is provided in the capitation rate. This adjustment reflects a CMO's commitment to provide rate increases in CY 2006 and CY 2007 at a level greater than that reflected in the base cost data. This adjustment is calculated to increase the rate base across all CMOs by the amount known to be provided for CY 2006 increases. This adjustment to all CMOs is consistent with the handling of provider rate increases in previous years in that rate increases provided by CMOs increase the rate base for all CMOs.

3. The Department is providing a hold harmless in CY 2007 for a correction to the geographic factor calculation identified after final rates were presented to CMOs on October 3, 2006. CMOs whose rates would have decreased under the correction will not get a decrease. CMOs with an increase under the correction will receive the increase.

**B. Comprehensive Non-MA Gross Rate**

The Comprehensive Non-MA Gross Rate is calculated as the Comprehensive MA Gross Rate multiplied by the square root of the ratio: Aggregate Non-MA PMPM Costs in CY 2005 (the base year) over Aggregate MA PMPM Costs in CY 2005. The square root of the cost ratio is used rather than the cost ratio itself to adjust for the minimal size of the non-MA population.

**C. Net MA and Non-MA Comprehensive Rates**

1. Gross MA and Non-MA rates are prospectively adjusted for cost share. To calculate the cost share adjustment, specific actuarial assumptions have been made with respect to the per member per month cost share dollar amounts, as determined by the Client Assistance for Re-employment and Economic Support System (CARES), for both MA and non-MA enrollees at the comprehensive level of care during the contract period of January 1, 2007, through December 31, 2007.

   The specific actuarial assumptions for the per member per month cost share as determined by CARES for MA and non-MA comprehensive enrollees are as follows:

| | MA Cost Share | Non-MA Cost Share |
|---|---|---|
| **Fond du Lac** | $47.64 | $601.70 |
| **La Crosse** | $65.24 | $386.37 |
| **Milwaukee** | $85.51 | $389.41 |
| **Portage** | $42.77 | $416.59 |
| **Richland** | $61.36 | $9.03 |

2. The CY 2007 comprehensive MA net rate includes prospective rate adjustments for individuals relocated from an ICF-MR to a Family Care CMO in CY 2006 or in October, November or December of CY 2005. Adjustments are made for relocated individuals without cost history in CY 2005 sufficient to represent the ongoing costs of the individuals and are provided only for individuals who enroll in the CMO with the purpose of relocating, and not ongoing CMO enrollees who may experience a stay in an ICF-MR. For each relocated individual with an approved care plan, a CMO's rate is adjusted to reflect the cost of the individual's care plan.

Comprehensive MA Net Rates, including prospective ICF-MR relocation adjustments, by CMO are:

| | Comprehensive MA Net Rates with ICF-MR Relocation Adjustments |
|---|---|
| Fond du Lac | $2,276.84 |
| La Crosse | $2,210.78 |
| Milwaukee | $2,109.45 |
| Portage | $2,516.05 |
| Richland | $2,302.11 |

These rates are calculated using the following projected CY 2007 MA comprehensive enrollment:

| | MA Comprehensive Months |
|---|---|
| **Fond du Lac** | 11,542 |
| **La Crosse** | 19,850 |
| **Milwaukee** | 71,720 |
| **Portage** | 11,231 |
| **Richland** | 3,961 |

## D. Intermediate Rate

Actual costs for serving Family Care members at an intermediate level of care were considered in developing the CY 2007 intermediate capitation rate. The CY 2007 intermediate rate is not changed from the CY 2006 intermediate capitation rate. Additional detail on the development of intermediate rates is found in the rate report submitted by PWC ("Family Care Capitation Rates, CY 2007").

## E. Stop Loss

The Department will provide stop-loss coverage for Community Care of Portage County and Richland County CMO. Of the five CMOs operating in CY 2006, only Community Care of Portage County and Richland County CMO may participate in stop loss in future contract years. Stop loss will not be offered to the other three existing CMOs in future years.

For any member in a covered CMO, stop-loss will pay 90% of the member's costs above $175,000, the attachment point.

A CMO must notify the Department when a member's costs reach $87,500 (50% of the attachment point). The Department may opt to review such member's costs for reasonableness prior to their costs reaching the covered threshold.

When a member's costs reach the threshold, CMOs must submit a reimbursement request to the Department. The Department will reimburse the CMO quarterly. Reimbursement will continue for claims incurred during the contract period up to six months after the end of the contract period.

The stop loss premium is paid through a capitation rate reduction. This reduction is $5.05 PMPM in CY 2007 for each participating CMO.

## F. Retrospective Adjustments

1. Cost Share: Actuarial assumptions of Cost Share will be updated at the end of the contract period with actual values. The capitation rates will then be re-calculated with the actual values replacing the assumed values. A retrospective rate adjustment will take place at that time to replace the capitation rate that is based on the assumed values with the capitation rate that is based on the actual values.

2. ICF-MR Relocations: Following the conclusion of the contract period, the per member per month MA capitation rate for the comprehensive level of care may be adjusted to reflect a rate for individuals relocating from ICF-MRs or State DD centers equal to the pre-approved projected cost of the individuals' care plan during enrolled months in 2007. This pertains only to individuals who enroll in the CMO for the purpose of relocating, and not ongoing CMO enrollees who may experience a stay in an ICF-MR. DHFS and CMOs will continue to use the established pre-approval process for the projected care plans.

   Retrospective adjustments will 1) provide approved care plan costs for individuals relocated in calendar years 2006 and 2007 and not captured in prospective ICF-MR relocation rate adjustments, and 2) ensure prospective adjustments equal the costs of the approved care plans. The second adjustment is necessary to account for differences in the projected CY 2007 enrollment used to calculate the prospective adjustment and actual CY 2007 enrollment.

   The rate will not be adjusted for actual costs or for individuals whose projected costs have not been approved. This adjustment pertains only to the current contract period and shall not be interpreted to apply to any other contract periods.

3. Nursing Home Downsizing or Closure: When requested by a CMO, the Department will consider an adjustment in the capitation rate if the CMO has experienced a significant cost increase due to an increase in the number of CY 2007 members who meet both of the following conditions:

- Have a nursing home stay greater than 100 consecutive days; and

- Become a Family Care member in CY 2007 within 32 days of their nursing home discharge date, or enroll in Family Care while residing a nursing home.

If the Department agrees with the adjustment request, it will calculate the adjustment as follows: A 2007 predicted PMPM based on the 2007 rate model will be calculated for the Family Care CMO's total eligible members, including the individuals meeting the above criteria. This calculated 2007 predicted PMPM will be compared to a 2007 predicted PMPM based on the 2007 rate model for Family Care CMO members that does not include the individuals meeting the above criteria. The rate adjustment will be equal to the difference in the two PMPM figures as calculated above.

The intent of this adjustment is to better reflect within the Family Care capitation rate method a significant change between the base population costs and CMO-specific enrollments that were used to calibrate the original capitation amounts, and the actual population that enrolls into each individual CMO. This adjustment pertains only to the current contract period and shall not be interpreted to apply to any other contract periods.

4. Ventilator Dependent Members: The Department will retroactively adjust the net MA comprehensive rate for the change in the number of members dependent on ventilators between the base year (CY 2005) and the rate year (CY 2007) for each CMO.

   The adjustment will be calculated as follows:

   - Identify the Statistical Model PMPM for each CMO's CY 2005 population with ventilator dependent members and without ventilator dependent members.

   - Calculate the PMPM difference between the two CY 2005 population amounts.

   - Identify the Statistical Model PMPM for each CMO's CY 2007 population with ventilator dependent members and without ventilator dependent members.

   - Calculate the PMPM difference between the two CY 2007 population amounts.

   - Subtract the CY 2005 population difference from the CY 2007 population difference. This amount is the retro-rate adjustment.

   The intent of this adjustment is to better reflect within the Family Care capitation rate method a significant change between the base population costs and CMO-specific enrollments that were used to calibrate the original capitation amounts, and the actual population that enrolls into each individual CMO. This adjustment pertains only to the current contract period and shall not be interpreted to apply to any other contract periods.

5. Diabetes Management Pay for Performance: CMOs that implement an effective diabetes management program as demonstrated by performance in three areas described below may receive an incentive payment in addition to their CY 2007 capitation payment calculated using the general rate methodology described above under Section V. Actuarial Basis.

   For CMOs that do not implement an effective diabetes management program as demonstrated by performance in three areas described below, the Department will reduce their CY 2007 capitation payment.

   **Overview, Incentive Payments, and Disincentives**

   Incentive payments and disincentive rate reductions are symmetrical around CMO's performance under CY 2006 Pay for Performance targets and CMO's performance under the CY 2006 Diabetes Management Pay for Performance project.

   CMOs are required to participate in the following three measurement areas:

   a. Documentation of one or more hemoglobin A1-c tests for diabetic members in the 13 month period prior to 12/31/2007;

   b. Improvement in the percentage of members with poorly controlled diabetes; and,

   c. Improvement in the rate of preventable diabetes-related hospitalizations and ER visits.

   For measure a., incentives and disincentives are symmetrical around the CY 2006 Pay for Performance targets. For measures b. and c., incentives and disincentives are symmetrical around CMO performance under CY 2006 Pay for Performance.

   For measure c., CMOs will select a risk margin for incentives and disincentives around their CY 2006 performance of the risk margin options offered below. CMOs will notify the Department in writing by 1/1/07 of their risk margin selection. This selection will be binding for the duration of the contract.

   In CY 2007, incentive and disincentive thresholds are as follows:

   a. Documentation of one or more hemoglobin A1-c tests for diabetic members in the 13 month period prior to 12/31/2007.

| Larger Disincentive | Small Disincentive | No fiscal effect | Small Incentive | Larger Incentive |
|---|---|---|---|---|
| < 67% | 67% - 72% | 73% - 78% | 79% - 83% | > 83% |

b. Improvement (decrease) in the percentage of members with poorly controlled diabetes.

| Larger Disincentive | Small Disincentive | No fiscal effect | Small Incentive | Larger Incentive |
|---|---|---|---|---|
| 4% increase | 2% increase | 2006 Actual Numbers | 2% decrease | 4% decrease |

c. Improvement (decrease) in the rate of preventable diabetes-related hospitalizations and ER visits.

**Risk Margin Option A**

| Larger Disincentive | Small Disincentive | No fiscal effect | Small Incentive | Larger Incentive |
|---|---|---|---|---|
| 20% increase | 10% increase | 2006 Actual Numbers | 10% decrease | 20% decrease |

**Risk Margin Option B**

| Larger Disincentive | Small Disincentive | No fiscal effect | Small Incentive | Larger Incentive |
|---|---|---|---|---|
| 40% increase | 20% increase | 2006 Actual Numbers | 20% decrease | 40% decrease |

Separate incentive payments and disincentives are provided/assessed for each measure. Of the $1,260,000 in funding available for incentive payments to all CMOs, one third will be made available for payments under each measure.

Incentive payments available to each CMO have been developed considering fixed costs for implementing a diabetes management program regardless of the number of diabetics enrolled in a CMO and variable costs due to differences in the number of diabetics in each CMO. The incentive payments and reductions by CMO in each measurement area are:

| **Measure 1: A1-c Testing Rate** | | | | |
|---|---|---|---|---|
| | Potential Larger Disincentive | Potential Small Disincentive | Potential Small Incentive | Potential Larger Incentive* |
| Fond du Lac | -$23,100 | -$15,700 | $15,700 | $23,100 |
| La Crosse | -$35,100 | -$23,900 | $23,900 | $35,100 |
| Milwaukee | -$155,800 | -$105,900 | $105,900 | $155,800 |
| Portage | -$21,300 | -$14,500 | $14,500 | $21,300 |
| Richland | -$14,700 | -$10,000 | $10,000 | $14,700 |
| *Subtotal* | *-$250,000* | *-$170,000* | *$170,000* | *$250,000* |

| **Measure 2: Improvement of Percent Members with Poorly Controlled Diabetes** | | | | |
|---|---|---|---|---|
| | Potential Larger Disincentive | Potential Small Disincentive | Potential Small Incentive | Potential Larger Incentive* |
| Fond du Lac | -$23,100 | -$15,700 | $15,700 | $23,100 |
| La Crosse | -$35,100 | -$23,900 | $23,900 | $35,100 |
| Milwaukee | -$155,800 | -$105,900 | $105,900 | $155,800 |
| Portage | -$21,300 | -$14,500 | $14,500 | $21,300 |
| Richland | -$14,700 | -$10,000 | $10,000 | $14,700 |
| *Subtotal* | *-$250,000* | *-$170,000* | *$170,000* | *$250,000* |

| **Measure 3: Improvement in the Rate of Preventable ER Visits and Hospital Admissions** | | | | |
|---|---|---|---|---|
| | Potential Larger Disincentive | Potential Small Disincentive | Potential Small Incentive | Potential Larger Incentive* |
| Fond du Lac | -$23,100 | -$15,700 | $15,700 | $23,100 |
| La Crosse | -$35,100 | -$23,900 | $23,900 | $35,100 |
| Milwaukee | -$155,800 | -$105,900 | $105,900 | $155,800 |
| Portage | -$21,300 | -$14,500 | $14,500 | $21,300 |
| Richland | -$14,700 | -$10,000 | $10,000 | $14,700 |
| *Subtotal* | *-$250,000* | *-$170,000* | *$170,000* | *$250,000* |
| | | | | |
| *TOTAL* | *-$750,000* | *-$510,000* | *$510,000* | *$750,000* |

*The larger incentive and disincentive amounts are in addition to the small incentive and disincentive amounts. The amounts are cumulative for CMOs that hit the thresholds for incentive payments or rate reductions.

**Measuring Performance**

Each CMO's performance will be measured in each performance area as follows:

a. Documenting one or more hemoglobin A1-c test(s) in the 13 month period prior to 12/31/07 for members with diabetes:

   i. At the end of CY 2007, each CMO will be required to run a December 31, 2007 report from its electronic database of clinical data for members with diabetes showing: 1) the number of diabetic members with one or more A1-c tests within the last 13 months from the report date, and 2) the number of members who are diagnosed with diabetes.

   - CMOs are required to maintain an electronic data system that includes their diabetic members' clinical tests, test dates and values.

   - For this portion of the Pay for Performance incentive, a CMO's data system must include all diabetic members' A1-c tests, test dates and values for tests completed between December 1, 2006 and December 31,

2007 and must be able to generate a report of members with diabetes, by Medicaid ID, and their A1-c tests, dates and values through December 31, 2007 as of January 31, 2008.

- DHFS will identify diabetic members using MMIS claims data and the LTCFS. If a CMO member has a diagnosis of diabetes in either data system and has been a Family Care member for three or more consecutive months, DHFS will count this individual as a CMO member with diabetes. DHFS will use screen and claims data in the MEDS data system by January 10, 2008. By this date, the MEDS data system includes screens completed through early December 2007 and claims for dates of service through November 2007.

- To identify potential discrepancies between the CMO's and DHFS' list of diabetics before January 2008, DHFS will provide its list to CMOs monthly.

- CMOs may request changes to DHFS' list of diabetics with justification. Justification includes but is not limited to: 1) physician confirmation that a member is not diabetic; 2) physician confirmation that a member is diabetic, but is receiving Hospice Care; or 3) physician confirmation that a diabetic member has decided with his/her primary physician to forgo diabetes treatment as a quality of life decision.

- DHFS will be responsible for verifying current enrollment of diabetic members.

- The number of members' A1-c tests reported by CMOs on 12/31/07 will be validated by MetaStar in February 2008. Validation will compare a sample of records from the CMO database to CMOs' member records. Metastar will also validate justifications for excluding members. Data must be validated by MetaStar prior to its consideration by DHFS for a CMO incentive payment.

ii. The number of diabetic members with one or more A1-c tests within the last 13 months from the report date will be used as the numerator and the total number of members with diabetes as the denominator in calculating the percentage of diabetic members with one or more A1-c tests in a year.

b. Improvement in the percentage of members with poorly controlled diabetes:

i. CMOs will be measured on their improvement in CY 2007 in the percent of diabetic members, enrolled for at least three consecutive months as of 12/31/06, with poorly controlled diabetes. CMOs will run a baseline measurement from CMOs' electronic databases with a December 31, 2006 run date. This baseline report will be compared to a final report run on December 31, 2007.

- Baseline data includes test dates and values for the most recent A1-c, LDL-C, and blood pressure tests performed on CMO members enrolled for at least three consecutive months as of 12/31/06 and identified as diabetic on 12/31/06 - each member has a test, test date and value for each of the tests (A1-c, LDL-C and blood pressure).

- This list of diabetics will have been validated by Metastar for CY 2006 Pay for Performance. In CY 2007, CMOs may request changes to this list with justification. Justification includes and is not limited to 1) physician confirmation that a member is diabetic, but is receiving Hospice Care or 2) physician confirmation that a diabetic member has decided with his/her primary physician to forgo diabetes treatment as a quality of life decision.

- MetaStar will validate baseline data and final data submitted under this portion of the Pay for Performance incentive. Validation will compare a sample of records from the CMO database to the CMOs' member records. Metastar will also validate justifications for excluding members. Data must be validated by MetaStar prior to it's consideration by DHFS for a CMO incentive payment.

ii. Improvement in the percent of members with poorly controlled diabetes will be calculated as a reduction in the combined average rate of members' A1-c tests with a value greater than or equal to 9%, LDL-C with a value greater than or equal to 100, and blood pressure with a systolic value greater than or equal to 140 or a diastolic value greater than or equal to 90. CMOs average improvement will account for changes in the number of diabetics between the baseline measure and final measure (i.e. the Department will account for dis-enrollments in the closed cohort).

- Please consider the following example to understand how improvement in the percentage of members with poorly controlled diabetes will be calculated:

  - At baseline (12/31/06) 100 members in CMO A are identified as having diabetes and have been enrolled for three consecutive months.

    50 have A1-c tests
    60 have LDL-C tests, and
    80 have blood pressure tests
    25 have an A1-c value ≥ 9%
    30 have LDL-C ≥ 100, and
    35 have a systolic blood pressure value ≥ 140 or a diastolic value ≥ 90.

  - The CMO's baseline percentage of members in poor control will be calculated as follows:

(25/50 + 30/60 + 35/80) / 3
= (.5 +.5 + .44)/3
= 48% of members in poor control

- On December 31, 2007, CMO A now has 90 members identified as having diabetes as of 12/31/06 (some of the original 100 members have disenrolled).

  80 have A1-c tests
  85 have LDL-C tests, and
  90 have blood pressure tests
  25 have an A1-c value ≥ 9%
  45 have LDL-C ≥ 100, and
  45 have a systolic blood pressure value ≥ 140 or a diastolic value ≥ 90.

- The CMOs final percentage of members in poor control will be calculated as follows:

  (25/80 + 45/85 + 45/90) / 3
  = (.31 +.53 + .5)/3
  = 45% of members in poor control

- The CMO's improvement in members with poorly controlled diabetes is the difference between 48% and 45%. This difference is 3%.

c. Improvement in the rate of preventable diabetes-related hospitalizations and ER visits:

   i. CMOs will be measured on their improvement (reduction) in CY 2007 in the rate of preventable diabetes-related hospitalizations and ER visits for diabetic members enrolled 1/1/06 through 12/31/07. These rate measures, developed by AHRQ, are:

| Indicator Name | Description |
|---|---|
| Diabetes Short-term Complication Admission Rate | Number of admissions for diabetes short-term complications per 1,000 diabetics. |
| Diabetes Long-term Complication Admission Rate | Number of admissions for long-term diabetes per 1,000 diabetics. |
| Uncontrolled Diabetes Admission Rate | Number of admissions for uncontrolled diabetes per 1,000 diabetics. |
| Rate of Lower-extremity Amputation Among Patients with Diabetes | Number of admissions for lower-extremity amputation among patients with diabetes per 1,000 diabetics. |

For ER visits that do not result in hospital admits, the Department will use the Short-term Complication, Long-term Complications, and Uncontrolled Diabetes diagnosis codes to measure ER visits.

ii. Prior to the start of the contract, a CMO will select their level of risk of the risk options offered and will notify DHFS by 1/1/07 of their selection.

iii. The baseline measurement for each CMO is the CY 2006 rate of preventable diabetes-related hospital admissions and ER visits for diabetic members enrolled 1/1/06 through 1/1/07.

iv. Reduction in the rate of preventable diabetes related hospitalizations and ER visits will be calculated as a reduction in the five rates added together. The denominator will be reduced to account for member disenrollments between the baseline measure and final measure. Individuals included in the baseline measure enrolled 1/1/06 through 1/1/07 who disenroll by 12/31/07 will be removed from the measure population (denominator) for CY 2007.

- The hospital data will include dates of service through December 31, 2007 and will be run in April 2008 to allow CY 2007 Medicaid claims run out.

- To allow CMOs to monitor their hospital measures throughout 2007, DHFS will generate four CMO specific reports prior to the final report that show the baseline data updated on May 10, July 10, and October 10, 2007, and January 10, 2008.

- The list of diabetics under this measure will have been validated by Metastar for CY 2006 Pay for Performance. In CY 2007, CMOs may request changes to this list with justification. Justification includes and is not limited to: 1) physician confirmation that a member is diabetic, but is receiving Hospice Care; or 2) physician confirmation that a diabetic member has decided with his/her primary physician to forgo diabetes treatment as a quality of life decision.

- MetaStar will validate final data submitted under this portion of the Pay for Performance incentive. Metastar will validate justifications for excluding members. Data must be validated by MetaStar prior to its consideration by DHFS for a CMO incentive payment.

- Please consider the following example to understand how improvement in the rate of members with preventable hospitalizations and ER visits will be calculated:

  - CMO A chooses risk option B. This risk option provides a small incentive payment for a 20% decrease and a larger incentive payment for a 40% decrease in the rate of hospitalizations and ER visits. This risk option also assesses a small disincentive at a 20% increase and a larger disincentive at a 40% increase in the rate of hospitalizations and ER visits.

- In CMO A, 120 diabetic members are enrolled from 1/1/06 through 1/1/07. These individuals have had 8 hospital admissions and ER visits, in total, in CY 2006.

- The CMO's baseline rate of hospitalizations and ER visits will be calculated as follows:

  8/120
  = 0.0666
  As a rate per 1,000 diabetics = 66.6

- On December 31, 2007, 100 members in the original CY 2006 group are still enrolled.

- On April 10, 2008, these 100 members have had 5 hospitalizations and ER visits in total during CY 2007.

- The CMO's final rate of hospitalizations and ER visits will be calculated as follows:

  5 / 100
  = 0.0500
  As a rate per 1,000 diabetics = 50.0

- The CMO's change in the rate of hospitalizations and ER visits is the percentage change from 66.6 to 50.0 calculated as: (50.0 – 66.6) / 66.6. This percentage change is -25%. [Note: a negative percentage means improvement].

- CMO A gets the minimum incentive under this portion of Pay for Performance since their improvement is greater than 20% but less than 40%.

These adjustments pertain only to the current contract period and shall not be interpreted to apply to any other contract periods. This adjustment is not conditioned on an intergovernmental transfer agreement.

## VI. Critical Incidents Protocol

### 1. Department Role in Relation to Critical Incidents

The Department is responsible for ensuring that CMOs have the capacity to identify and respond to critical incidents in a manner that assures the health and well being of Family Care enrollees. The Department needs documentation of critical incidents in order to:

a. Ensure the health and well being of Family Care enrollees and others.

b. Demonstrate that the health and well being of persons served through the Family Care waiver are protected.

c. Analyze incidents for patterns or trends, monitor the promptness and appropriateness of interventions and provide appropriate feedback and technical assistance to CMOs.

### 2. CMO Responsibility to Identify and Respond to Critical Incidents and Unexpected Deaths

In the Family Care environment, it is the responsibility of the CMO to develop the capacity to detect and respond in an effective manner to critical incidents and unexpected deaths. To accomplish this, each CMO must establish procedures, as part of its health and safety plan, to:

a. Train CMO and contracted provider staff in identifying, responding to and documenting and reporting critical incidents and unexpected deaths.

b. Ensure that CMO and contracted provider staff respond appropriately to critical incidents and unexpected deaths.

c. Maintain enrollee-specific information in enrollee records about unexpected deaths, responses by the CMO and any other agency, and make that information available to the Department upon request.

d. Maintain enrollee-specific information about critical incidents, responses by the CMO and any other agency, and enrollee outcomes, and make that information available to the Department upon request.

e. Ensure CMO management review and analysis of critical incidents, including unexpected deaths, to determine whether responses to specific individual incidents were appropriate, and if strategies can be identified for reducing or eliminating some causes of critical incidents.

f. Develop and maintain effective relationships with other relevant systems (e.g., Adult Protective Services/Elder Abuse).

g. Share information about critical incidents and unexpected deaths locally and with the Department in order to continually improve CMO services, systems and enrollee outcomes.

h. An unexpected death is any death that:

- Must be reported to the coroner or medical examiner by statute (s. 979.01 Stats.) or regulation;
- Is reported to the Department of Regulation and Licensing or any part of the Department of Health and Family Services;
- Is a result of trauma;
- Occurs under suspicious, obscure or otherwise unexplained circumstances; or,
- Occurs while a grievance, appeal or fair hearing is pending at the time of death.

**3. Documenting Critical Incidents/Unexpected Deaths and CMO Responses**

The primary purpose for collecting information about critical incidents and CMO responses is to meet CMO needs to maintain sufficient documentation in order to:

a. Intervene or take appropriate actions to remove or ameliorate hazards to the health or well being of its members.

b. When there has been harm to a member, to document the root causes of the harm and what actions were taken to prevent further or future harm.

c. Where there has been an accidental or unexpected death, document whether or not preventable circumstances contributed to the death and what actions were taken to address those circumstances to help prevent similar instances.

d. Document compliance with other statutory requirements, e.g., "Safe Medical Devices Act."

e. Continually improve member outcomes, services and case management by analyzing CMO responses to critical incidents, and developing appropriate policies and procedures for responding in a coordinated manner through its case management, network contracting and appeal and grievance systems, and its health and safety and quality improvement plans.

f. Document compliance with reporting requirements of other relevant systems (e.g., APS, Elder Abuse Reporting System, local law enforcement and courts), and analyze and continually improve the effectiveness of CMO relationships with those systems.

**4. CMO Requirements to Report Critical Incidents and Unexpected Deaths**

a. Local Reporting Requirements – The CMO is responsible for gathering and reporting information related to critical incidents and unexpected deaths locally:

i. Internally to its Governing Board, internal committees, Network Developer and QA/QI Coordinator.

ii. Externally to the Local LTC Council.

b. Family Care Reporting Requirements – The CMO is responsible for gathering and reporting information related to critical incidents, including:

i. Reporting unexpected and accidental deaths, and any death potentially due to abuse or neglect as soon as possible after the death, but within forty-eight (48) hours of when the CMO learns of the death, per the steps in item 6, below.

ii. Reporting aggregate information related to critical incidents and unexpected deaths as part of each CMO's quarterly report to the Department. Using this venue, CMOs are asked to report aggregate data, not information about specific individuals, incidents or CMO responses.

iii. Reporting any other enrollee-specific information as needed and requested by the Department.

c. Other Reporting Requirements

i. The CMO and/or its contracted providers is not relieved of other certification, licensing or regulatory requirements for reporting of critical incidents, including requirements to report and investigate deaths or abuse and neglect of residents of certain facilities (e.g., s. 50.034, s. 50.04 Stats., chs. HFS 12, 13, 83 and 88 Wis. Adm. Code).

ii. Whenever an employee of the CMO or any of its subcontract agencies believes that abuse, material abuse, neglect or self-neglect of an elder person has occurred, the employee shall make a report to the agency designated under s. 46.90 Stats.

**5. Standardized Reporting Elements in Quarterly Reports**

To be most useful, the aggregate data reported in quarterly reports to the Department will have to be consistent across CMOs. To achieve that consistency, CMOs are to include the following standardized data elements:

a. Total number of critical incidents.

b. Number of critical incidents by type:

i. Deaths due to abuse, neglect or exploitation.

ii. Physical harm due to abuse, neglect or exploitation.

iii. Mental/emotional harm due to abuse, neglect or exploitation.

iv. Substantial loss in value of the personal or real property of an enrollee due to theft, damage or exploitation.

c. Number of critical incidents by provider type (i.e. day services, residential provider etc.) where the incident occurred.

d. Analysis of any conclusions made by the CMO regarding whether responses to specific individual incidents were appropriate, and if strategies can be identified for reducing or eliminating some causes of critical incidents.

e. Any problems the CMO could not resolve in responding to critical incidents, or technical assistance the CMO would like related to critical incidents.

## VII. Performance Improvement Projects

### A. Overview

A Performance Improvement Project must be designed to improve outcomes for the CMO membership overall or a group of members who have similar care and service needs.

CMOs may satisfy the requirements of this addendum by participating in collaborative Performance Improvement Projects in conjunction with one or more CMOs.

### B. Performance Improvement Projects: Schedule

1. CMOs will work with the Department and its EQRO, MetaStar, Inc., to complete their projects using a defined performance improvement model or method. One example of a defined method is the Best Clinical and Administrative Practices (BCAP) method. Other models or methods may also be used depending on the type of project undertaken. Following are the sequence, events and timeline for Performance Improvement Projects:

    a. Form a project team to design, test and implement system changes on their selected PIPs.

    b. Identify a CMO senior leader who will actively support the team

    c. Provide the resources necessary to support the team, including staff time to devote to the effort.

    d. Use a structured model of improvement that includes a process for identifying and selecting areas for improvement, systematic analysis, and a plan-do-study-act (PDSA) improvement cycles.

    e. Submit interim reports and participate in conference calls when requested (no more frequently that quarterly) identifying progress and PDSA cycles implemented.

    f. Document on going progress on activity logs, worksheets, workbooks, or some other consistent format.

    g. Maintain and safeguard the confidentiality of privileged data or information – whether written, photographed, or electronically recorded and whether generated or acquired by the team – which can be used to identify an individual member and providers.

## C. Performance Improvement Projects: Components

### 1. Project Steps

There are basic steps that any performance improvement project should include, regardless of the model or method used. These steps include:

**Step 1: Selecting the topic.**
Topics for PIPs should be selected based on their relevance to the CMO's membership and should focus on important aspects of care and/or outcomes for Family Care members (outcomes are listed in Part 2 of this article).

**Step 2: Defining the study questions and/or project aims/goals.**
Each study or project should have clearly defined study questions and/or project aims. Baseline studies should have clearly stated study questions, while projects that are in the intervention phase should have clearly stated project aims that include numerical goals and target dates.

**Step 3: Selecting project indicators and measures.**
Projects should have clearly defined indicators and measures. Whenever feasible, the CMO should consider the use of existing indicators. Indicators should relate to the study questions and/or project aims and have clearly defined corresponding measures. Each measure's numerator and denominator should be clearly defined with documented specifications.

**Step 4: Using a representative and generalizable population.**
The CMO should identify the relevant population the study or project is aimed at and clearly define any inclusion or exclusion criteria, including eligibility criteria. If the CMO is stratifying the relevant study or project population, they should consider stratifying by high risk, high utilization, or high needs.

**Step 5: Using sound sampling techniques (if sampling is performed).**
If part of the study or project includes the use of a sample group, the CMO should use methodologically sound sampling techniques when selecting the sample group.

**Step 6: Reliably collecting data.**
Each project should have a prospective plan for data collection and analysis. This plan should address data collection methods, data storage, data aggregation and data analysis. The plan should identify who will be involved in data collection, analysis and interpretation. If data being collected are more implicit in nature, the CMO should have a plan for ensuring that data collectors are appropriately qualified and trained in the use of data collection instruments.

**Step 7: Implementing interventions and improvement strategies.**
Interventions and improvement strategies should be considered that are likely to result in desired improvement. Interventions should be tested on small pilot groups

using P-D-S-A cycles to determine their effectiveness prior to full implementation. The CMO should develop ways of measuring the implementation and effectiveness of all interventions. When barriers are encountered, they should be analyzed and addressed.

**Step 8: Analyzing data and interpreting results.**
Each study or project should include baseline and repeat measurements. Project data should be periodically reviewed and analyzed to determine if the project is accomplishing what it was designed to do.

**Step 9: Determining "real" improvement.**
Improvement should be assessed to determine if it is real improvement (i.e. if improvement resulted from planned interventions as opposed to artifact from a short-term event that is unrelated to the intervention, or random chance.) Tests for statistical significance should also be conducted to help determine if improvement is statistically significant.

**Step 10: Achieving sustained improvement.**
Each project should include a plan for how real improvement, once achieved, will be sustained. This should include a plan for periodic monitoring of project indicators.

**2. Annual Reports**
The CMO shall report the status and results of each project to DHFS annually. The annual report shall include information about each step of the improvement project.

## Part 2: Outcomes in Long-Term Care

Assisting people to achieve their desired individual quality-of-life outcomes is one of the primary goals of our long-term care system. The following statements demonstrate the areas of life that people in long-term care programs have identified as being important to their quality of life. These statements provide a framework for learning about and understanding the individual's needs, values, preferences, and priorities in the assessment and care planning process and in monitoring the quality of our long-term care programs.

CHOICE
Outcome: I decide where and with whom I live.
Outcome: I make decisions regarding my supports and services.
Outcome: I decide how I spend my day.

PERSONAL EXPERIENCE
Outcome: I have relationships with family and friends I care about.
Outcome: I do things that are important to me.
Outcome: I am involved in my community.
Outcome: My life is stable.
Outcome: I am respected and treated fairly.
Outcome: I have privacy.

HEALTH AND SAFETY
Outcome: I have the best possible health.
Outcome: I feel safe.
Outcome: I am free from abuse and neglect.

## VIII. Data Certification

### CERTIFICATION INSTRUCTIONS

**Encounter Data Certification**
This certification requires the responsible party to attest that the submitted Encounter Data is accurate, complete and truthful to the best of his/her knowledge. This is required by Federal Code 42 CFR 438.600 (e.g.) and the Health and Community Supports contract. **It is the responsibility of the certifying party to assure the necessary internal checks, audits, and testing procedures have been conducted to ensure the integrity of the data.**

After the CMO is sent the **submission status report** indicating that the CMO's data has been **accepted**, certification shall be made via the automated data certification method or, when the automated function is not available, via the Data Certification Form, which is provided by DHFS in accordance with 42 CFR 438.600. If it is necessary to use the form, it shall be submitted to:

CMO Team
DHFS/DDES/BLTS
1 West Wilson St., Room 518
PO Box 7851
Madison, WI 53707-7851

**Financial Certification**
This certification requires the responsible party to attest that the submitted financial statement is accurate, complete and truthful to the best of his/her knowledge. This is required by Federal Code 42 CFR 438.600 (e.g.) and the Health and Community Supports contract. **It is the responsibility of the responsible party to develop the necessary internal checks, audits, and testing procedures to assure the integrity of the financial statement.**

Certification must be included with submission of the financial statement to the State. Submit the completed form to:

CMO Team
DHFS/DDES/BLTS
1 West Wilson St., Room 518
PO Box 7851
Madison, WI 53707-7851

**STATE OF WISCONSIN**
**DIVISION OF DISABILITY AND ELDERLY SERVICES**
(4/04)

BUREAU OF LONG-TERM SUPPORT
1 WEST WILSON ST ROOM 518
PO BOX 7851
MADISON WI 53707-7851

Telephone: (608) 267-7286
FAX: (608) 266-5629

## ENCOUNTER DATA CERTIFICATION

Pursuant to the Health and Community Supports contract(s) between the State of Wisconsin, Department of Health and Family Services, Division of Disability and Elder Services, and the _____ _____ Care Management Organization, hereafter known as the CMO. The CMO certifies that: The business entity named on this form is a qualified provider enrolled with and authorized to participate in the Wisconsin Medicaid program as a CMO. The CMO acknowledges that Federal Code 42 CFR 438.600 (e.g.) requires that the data submitted must be certified by a Chief Financial officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The CMO hereby requests payment from the Wisconsin Medicaid program based on encounter data submitted and in so doing makes the following certification to the State of Wisconsin as required by Federal Code 42 CFR 438.600 (e.g.).

The CMO has reported to the State of Wisconsin for the month/year of _____ all new encounters included in batch ID# _____. The CMO has reviewed the encounter data for the period and batch listed above
and I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to the State of Wisconsin in this batch is accurate, complete, and truthful. No material fact has been omitted from this form.

I, _____(enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) **acknowledge that the information described above may directly affect the calculation of payments to the CMO. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact.**

**SIGNATURE - NAME AND TITLE OF CFO, CEO OR DELEGATE** **DATE SIGNED**

**STATE OF WISCONSIN**
**DIVISION OF DISABILITY AND ELDERLY SERVICES**
(4/04)

BUREAU OF LONG-TERM SUPPORT
1 WEST WILSON ST ROOM 518
PO BOX 7851
MADISON WI 53707-7851

Telephone: (608) 267-7286
FAX: (608) 266-5629

## FINANCIAL STATEMENT CERTIFICATION

Pursuant to the Health and Community Supports contract(s) between the State of Wisconsin, Department of Health and Family Services, Division of Disability and Elder Services, and the _____ _____ Care Management Organization, hereafter referred to as the CMO. The CMO certifies that: The business entity named on this form is a qualified provider enrolled with and authorized to participate in the Wisconsin Medicaid program as a CMO.

The CMO acknowledges that if payment is based on any information required by the State and contained in financial statements, Federal Code 42 CFR 438.600 (e.g.) requires that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The CMO hereby requests payment from the Wisconsin Medicaid program based on any information required by the State and contained in financial statements submitted and in so doing makes the following certification to the State of Wisconsin as required by Federal Code 42 CFR 438.600 (e.g.).

The CMO has reported to the State of Wisconsin for the period of _____ (indicate dates) all information required by the State and contained in financial statements. The CMO has reviewed the information submitted for the period listed above and I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to the State of Wisconsin in this batch is accurate, complete, and truthful. No material fact has been omitted from this form.

I, _____ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) **acknowledge that the information described above may directly affect the calculation of payments to the CMO. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact.**

**SIGNATURE - NAME AND TITLE OF CFO, CEO OR DELEGATE** **DATE SIGNED**

## IX. CMO Certification and Re-Contracting

The CMO is required to meet certification standards as prescribed in ss. 46.284 (2) and (3) Stats., and HFS 10.43. In addition, the CMO must meet standards of performance prescribed in HFS 10.44 as well as those outlined in this Health and Community Supports Contract. The CMO shall provide to the Department whatever information and documents the Department requests the CMO to provide to it so that it can determine whether the CMO is meeting these standards. The Department will make a request for the required items by September 15 of each calendar year. The CMO agrees to submit the requested information by the deadlines identified in the annual request.

## X. Service Definitions: Family Care Benefit Package

A. The following services are defined in Wisconsin's CMS (Centers for Medicare & Medicaid Services) approved s. 1915 (c) home and community-based waiver services waivers: #0367.90 and #0368.90 under s. 46.281 (1) (c) Stats., as follows:

1. **Adaptive aids** are controls or appliances that cannot be obtained through Wisconsin's approved MA State Plan. They are aids that enable persons to increase their abilities to perform activities of daily living or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services and material benefits that enable individuals to access, participate and function in their community. These include the purchase of vehicle modifications (such as van lifts, hand controls, equipment modifications etc. that allow the vehicle to be used by the participant to access the community), or those costs associated with the maintenance of these items.

2. **Adult day care services** are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision and/or protection. Services may include personal care and supervision, light meals, medical care, transportation to and from the day care site. Transportation between the individual's place of residence and the adult day health center may be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

3. **Care/case management services** (sometimes called support and service coordination) are provided by an interdisciplinary care management team (IDT). The participant is the center of the IDT. The IDT consists of, at minimum, a registered nurse and a social services coordinator, and may also include other professionals as appropriate to the needs of the participant and family or other informal supports requested by the participant. The IDT initiates and oversees the initial comprehensive assessment process and reassessment process, the results of which are used in developing the individual's participant-centered plan of care. The IDT identifies the participant's preferred outcomes and the services needed to achieve those outcomes and monitors the participant's health and welfare, the delivery of services, and progress in achieving identified outcomes. The IDT also carries out activities that help participants and their families identify other service needs and gain access to medical, social, rehabilitation, vocational, educational and other services identified.

4. **Communication aids** are devices or services needed to assist with hearing, speech or vision impairments in order to access and deliver services. These services assist the individual to effectively communicate with service providers, family, friends and the general public, decrease reliance on paid staff, increase personal safety, enhance independence, and improve social and emotional well-being. Communication aids include: communicators, speech amplifiers, aids and assertive devices, interpreters (as specified below), and cognitive retraining aids, (including repair) and are items not covered under the Medicaid state plan.

Interpreter services are usually considered, and should be reported as, an administrative expense.

Interpreter services may be considered services under communication aids only when the interpreter service is needed to assist the individual to participate in community activities that are authorized by the interdisciplinary team as part of the member's individualized service plan, and interpreter services are not otherwise available (e.g., any public and private organizations provide interpreter services upon request).

Communication aids does not include interpreter services:

- Needed to facilitate communication with CMO staff, in which case the interpreter service is an administrative cost of the CMO;
- Needed to facilitate communication with any subcontracted service provider, in which case the interpreter service is an administrative cost of the subcontracted service provider that may be included in the rate the CMO pays the provider; or
- Needed to facilitate communication with any Medicaid State Plan service provider, in which case the Medicaid State Plan service provider is expected to provide the interpreter service as an administrative cost under the rate paid by Medicaid.

5. **Consumer-directed supports** – called "self-directed supports" (SDS) in Family Care – is the provision of a flexible array of services provided to participants that include a specified portion of the participant's authorized waiver services. This particular service includes only the cost of a service broker if the consumer chooses that assistance. Service brokers are subject to criminal background checks and must be independent of any other waiver service provider.

   The cost of any direct services authorized and obtained by a consumer through an SDS plan is reported under the appropriate service definition. The cost of fiscal agent and other supportive services are provided and reported as financial management services. Care management services the CMO is required to provide to all members is excluded.

   Each CMO must have a SDS plan, approved by the State. An approved CMO SDS plan will ensure that SDS is implemented through processes characterized by:

   - Support for the consumer and those close to the consumer to assist in identifying the consumer's desired outcomes and the means of achieving those outcomes, in a manner that reflects consumer preferences as closely as possible.

   - Planning that occurs within the limits of an individualized budget that is based on typical service costs for waiver participants with similar needs in similar situations.

- An emphasis on identifying and strengthening networks of informal supports and on making use of generic community resources to the maximum extent possible.

- Identification of how participants will be supported in service planning, implementation, and how the participant's SDS plan will be monitored to ensure participant health and welfare, including ensuring that SDS services are provided by individuals or entities that are qualified to meet the unique needs and preferences of the participant.

6. **Consumer education and training** are designed to help a person with a disability develop self advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. Includes education and training for participants, their caregivers and/or legal representatives that is directly related to building or acquiring the skills described above. Excludes educationally related services available under IDEA or other relevant funding sources. Excludes education/training costs exceeding $2500 per participant annually. Excludes payment for hotel and meal expenses while participants, or their legal representatives attend allowable training/education events. Local agencies will assure that information about educational and/or training opportunities is made available to participants and their caregivers and legal representatives.

7. **Counseling and therapeutic resources** are services that are needed to treat a personal, social, behavioral, cognitive, mental or alcohol or drug abuse disorder. Services are usually provided in a natural setting or service office. Services include: counseling to assist in understanding capabilities and limitations or assist in the alleviation of problems of adjustment and interpersonal relationships, recreational therapy, music therapy, nutritional counseling, medical and legal counseling, and grief counseling.

8. **Financial management services** are the provision of services to assist waiver participants and their families to manage service dollars or manage their personal finances. This service includes a person or agency paying service providers after the participant, guardian or family authorizes payment to be made for services included in the participant's approved individualized service plan. Financial Management Services providers, sometimes referred to as fiscal intermediaries, are organizations or individuals that write checks to pay bills for personnel costs, tax withholding, worker's compensation, health insurance and other taxes and benefits appropriate for the specific provider consistent with the individual's ISP or budget for services. Financial management services are purchased directly by the CMO and made available to the participant/family to insure that appropriate compensation is paid to providers of services. Also includes the provision of assistance to waiver participants who are unable to manage their own personal funds to assist them manage their personal resources. Includes assistance to the participant to effectively budget the participant's personal funds to ensure sufficient resources are available for housing, board and other essential costs. The costs of the housing and board are not covered by the waiver. Includes paying bills authorized by the participant or their guardian, keeping an account of disbursements and assisting the participant ensure that

sufficient funds are available for needs. This service is necessary to prevent institutionalization. Excludes payments to court appointed guardians or court appointed protective payees if the court has directed them to perform any of these functions.

9. **Habilitation** is the delivery of services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services. Habilitation includes:

    a) **Daily living skills training** is the provision of training in activities of daily living such as child-rearing skills, money management, home care maintenance, food preparation and accessing and using community resources. Daily living skills training are provided in a residential setting and are intended to improve the participant's ability to perform routine daily living tasks, improve ability to utilize greater independence by either training the participant or the caregiver to perform activities with greater independence.

    b) **Day center service/treatment** is the provision of regularly scheduled activities in a non-residential setting (day center) to enhance social development and to develop skills in performing activities of daily living and community living. Day services include services primarily intended for disabled adults. Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services. Day center services may be provided to supplement, but may not duplicate services provided under vocational futures planning provided under the waiver.

    c) **Day services for children** are the provision of services that provide children with regularly scheduled activities for part of the day. Services include training, coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs that provide after school supervision, daytime services when school is not in session, and services to pre-school age children. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families. Coordination activities may involve the implementation of components of the child's family-centered and individualized

service plans and may involve family, professionals, and others involved with the child as directed by the child's plan. Day Services for children also include the provision of supplementary staffing necessary to meet the child's exceptional care needs. Day Services for children also include the provision of supplementary staffing necessary to meet the child's exceptional care needs. Excludes any services available through public education programs. Excludes the basic cost of day care unrelated to a child's disability (i.e., the rate paid for children who do not have special needs). Excludes any service that falls under the definition of daily living skills training, prevocational services, or respite care. Excludes services provided to children under the age of 17 years and 9 months.

For children with physical or personal care needs, the types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catheterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care.

Providers are required to have criminal background checks and specialized training related to the child's unique needs in order to effectively address the needs and to ensure the health safety and welfare of each child served. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

**d) Prevocational services** is the provision of services intended to prepare an individual for paid or unpaid employment but which are not job task oriented. Services include teaching an individual such concepts as following directions, attending to tasks, task completion problem solving, safety and mobility training. Prevocational services furnished under the waiver are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17). Prevocational services may be provided to supplement, but may not duplicate services provided under vocational futures planning provided under the waiver. Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

**e) Supported employment services** is the provision of support to maintain paid, competitive employment in an integrated work setting to individuals who, because of their disabilities, need intensive on-going support to perform in a work setting. Supported employment services include supervision, training, transportation services needed to provide intensive ongoing support, and any activity needed to sustain paid work by the participant, i.e., supported employment assessment,

supported employment job placement, supported employment training, and supported employment follow-up. Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Supported employment services may be provided to supplement, but may not duplicate services provided under vocational futures planning provided under the waiver.

f) **Vocational futures planning (VFP)** is a consumer-directed, team based comprehensive employment service that supports waiver program participants to obtain, maintain or advance in employment. The agency providing vocational futures planning services will ensure that it includes: identification of the barriers to work, including an assistive technology pre-screen and, if required, an in-depth comprehensive assessment; benefits analysis; resource team coordination; career exploration; job seeking support; and ongoing support. Vocational futures planning must be done by a team of qualified professionals that includes, at a minimum, an employment specialist, a benefits counselor and an assistive technology consultant. Vocational futures planning furnished under the waiver are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602 (61) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17). When this service is provided the member record must contain activity reports, completed by the VFP Team and filed within thirty (30) days of completing each of the six required activities, and monthly ongoing support reports from the VFP Team. Vocational futures planning excludes services that could be provided as supported employment or prevocational sheltered employment and work activity services.

10. **Home delivered meals** or "meals on wheels" include the costs associated with the purchase and planning of food, supplies, equipment, labor and transportation to deliver one or two meals a day to recipients who are unable to prepare or obtain nourishing meals without assistance. This service will be provided to persons in natural or supportive service settings to promote socialization and adequate nutrition.

11. **Home modifications** are services and items that assess the need for, arrange for and provide modifications and or improvements to a participant's living quarters to allow for community living, provide safe access to and within the home, reduce the risk of injury, facilitate independence and self-reliance, allow the individual to perform more ADLs or IADLs with less assistance and decrease reliance on paid staff. Home modifications must be necessary to increase self-reliance and independence, or to ensure safe, accessible means of ingress/ egress to a participant's living quarters, or to otherwise provide safe access to rooms, facilities or equipment within the participant’s living quarters, or adjacent buildings that are part of the residence. Home modifications may include ramps; stair lifts, wheelchair lifts, or other mechanical devices to lift persons with impaired mobility from one vertical level to another; kitchen/bathroom modifications; specialized accessibility/safety adaptations; voice-activated, light-activated, motion-activated and electronic devices that increase the participant’s self-reliance and capacity to function independently. Modifications

which increase the square footage, or that enhance the general livability and value, of a privately owned residence are excluded.

12. **Housing counseling** is a service which provides assistance to a recipient when acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of the housing counseling is to promote consumer choice and control of housing and access to housing that is affordable and promotes community inclusion. Housing counseling includes exploring both home ownership and rental options, and both individual and shared housing situations, including situations where the individual lives with his or her family. Services include counseling and assistance in identifying housing options, identifying financial resources and determining affordability, identifying preferences of location and type of housing, identifying accessibility and modification needs, locating available housing, identifying and assisting in access to housing financing, and planning for ongoing management and maintenance. A qualified provider must be an agency or unit of an agency that provides Housing Counseling as a regular part of its mission. Counseling must be provided by staff with specialized training and experience in housing issues and shall be available to anyone in the general public who needs assistance with housing. Waiver funds may not be used to purchase this service if it is otherwise provided free to the general public. Excludes reimbursement if this service is provided by an agency that also provides residential support services or support/service coordination to the waiver participant. Excludes funding for physical alterations of a person's home to address accessibility, which are included under Home Modifications. Excludes funds to pay for items necessary for housing start up expenses, which are include under Relocation Services.

13. **Personal emergency response system (PERS)** is a device which provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate assistance in the event of a physical, emotional or environmental emergency.

14. **Relocation services** includes the payment of certain costs associated with the relocating from an institution. Costs may include the initial fees to establish utility service and the purchase of essential items and services needed to establish a community living arrangement. Relocation related housing start up services includes person-specific services, supports or goods that may be arranged, scheduled, contracted or purchased, and that will be put in place in preparation for the participant's relocation to a safe, accessible community living arrangement. There is no institutional length of stay requirement that must be met in order to access this service. Services may be provided up to 180 days prior to discharge. May include payment of initial utility (heating, electric, water and telephone) connection costs and or fees; the purchase of essential home furnishings, such as necessary basic furniture and kitchen appliances not furnished in the housing arrangement; telephone(s), cooking/ serving utensils, basic cleaning equipment and household supplies as well as basic bathroom and bedroom furnishings; payment of a security deposit; services to move personal belongings and to prepare the selected community living arrangement, including general cleaning and the organization of household supplies and

furnishings. Excludes purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc); and excludes the use of waiver funds to purchase service agreements or extended warranties for appliances or any other home furnishings. Criminal, caregiver and licensing background checks are required for providers of relocation services who meet the definition of a caregiver.

15. **Residential Care**. Nursing services under the following residential services are provided in accordance with the standards of Wisconsin's Nurse Practice Act.

    a) **Adult family homes for 1-2 beds** are residences in which the owner of the residence provides care and maintenance above the level of room and board, but not including nursing care to one or two residents.

    b) **Adult family homes for 3-4 beds** are small congregate care settings where 3-4 adults who are not related to the operator reside and receive care, treatment, support, supervision and training that is provided as needed for support in one or more aspects of living such as: health care, personal care, supervision, behavior and social supports, daily living skills training and transportation when transportation is part of providing the services and that may include several hours per week of nursing care per resident. Room and board costs are not included in the services the person receives.

    c) **Children's foster homes/treatment foster homes** are family oriented residences operated by a person licensed under s.48.62 Wis. Stats. and HFS 56 Wis. Adm. Code as a foster home or residences operated by a provider licensed under HFS 38 Wis. Adm. Code as a treatment foster home. Children’s foster homes and treatment foster homes provide care and maintenance for no more than four foster children, with exceptions for more children if all the foster children are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including : health care, personal care, supervision, behavior and social supports, daily living skills training, and transportation.

       Excludes the cost of room and board provided by the foster home provider. Excludes the cost of basic support and supervision provided by the foster care provider. Excludes home modifications, adaptive equipment or communication aids.

       Excludes services provided to children under the age of 17 years and 9 months.

       Includes supplementary intensive supports and supervision services to address exceptional physical or personal care needs. Examples to illustrate the range and scope of children’s exceptional physical or personal care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares, exhibits eating or feeding problems including tube or gavage feedings, requires specialized skin and positioning care to treat or prevent serious skin conditions such as pressure

sores, requires follow-through on a therapy plan in excess of 2 hours per day, requires persistent monitoring of complex medical needs, or is non-ambulatory.

For children with physical or personal care needs, the types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catheterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care.

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

**d) Community-based residential facilities (CBRF)** are larger congregate care settings where 5 or more adults who are not related to the operator or administrator reside and receive care, treatment, support, supervision and training that is provided as needed for support in one or more aspects of living such as: health care, personal care, supervision, behavior and social supports, daily living skills training and transportation when transportation is part of providing the services and that may include several hours per week of nursing care per resident. Room and board costs are not included in the services the person receives.

For persons with developmental disabilities, a variance must be obtained from the Department of Health and Family Services for the individuals on the waiver to live in a CBRF. Variances will be granted only for facilities with 5 to 8 beds.

For elders and persons with physical disabilities no bed size limit is imposed because FHFS has determined that, although bed size has historically been used as a proxy for whether a facility is really "community-based," the interdisciplinary case management team which includes the consumer, can more effectively monitor the nature and quality of facilities, rather than continuing to administratively impose bed size limits. Among the factors to be considered in such monitoring is the importance of privacy to the individual consumer and in larger facilities the extent to which the consumer's "residence" is physically separated from that of others (e.g. separate lockable door, bathroom, kitchen facilities etc.). Each CMO network is required to include facilities that offer such physical separateness in various residential service settings including CBRFs, adult family homes, RCACs and nursing homes.

**e) Residential care apartment complexes (RCAC)** are services provided in a homelike, community-based setting where 5 or more adults reside in their own living units that are separate and distinct from each other. Persons who reside in

the facility also receive the following services: supportive services, personal assistance, nursing services, and assistance in the event of an emergency.

16. **Respite care services** are services provided to a waiver eligible participant on a short-term basis to relieve the participant's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in an institution such as a certified Medicaid setting (hospital, nursing home) or other licensed facility. Respite care may also be provided in a residential facility such as a certified or licensed Adult Family Home, licensed CBRF, Child Caring Institution, children's foster home, children's treatment foster home, children's group home, certified Residential Care Apartment Complex, in the participant's own home or the home of a certified respite care provider. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence or a residential care apartment complex.

17. **Specialized medical equipment and supplies** are those items necessary to maintain the participant's health, manage a medical or physical condition, improve functioning or enhance independence. Items or devices provided may be in excess of the quantity of medical equipment or supplies covered under the Medicaid state plan when coverage of the additional items or devices has been denied. Items or devices provided must be of direct medical or remedial benefit to the participant. Allowable items devices or supplies may include incontinence supplies, wound dressings, IV or life support equipment, orthotics, nutritional supplements, vitamins, over the counter medications and skin conditioning lotions/lubricants. Additionally allowable items may include books and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, humidifiers and water treatment systems may be allowable when needed to support a participant's health and safety outcomes. Excludes separate additional charges for shipping, handling, mailing or delivery of items.

18. **Specialized transportation services** assist in improving an individual's general mobility and ability to perform tasks independently and to gain access to waiver and other community services, activities and resources. Services can consist of material benefits such as tickets or other fare medium needed as well as direct conveyance of participants and their attendants to destinations.

19. **Supportive home care (SHC) services** are services to provide necessary assistance for eligible persons in order to meet their daily living needs and to insure adequate functioning at home, in small integrated alternate care settings and in the community. Supportive home care services differ from the State plan services in that they are monitored by case managers and provide services as indicated in a plan of care. Services include:

    a) Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event. They include: outdoor activities such as yard work and snow shoveling; indoor activities such as window washing, cleaning of attics and basements, cleaning of carpets, rugs and drapery, and

refrigerator/freezer defrosting; and the necessary cleaning of vehicles, wheelchairs and other adaptive equipment and home modifications such as ramps.

b) Hands-on assistance with activities of daily living such as dressing/undressing, bathing, feeding, toileting, assistance with ambulation (including the use of a walker, cane, etc.), care of hair and care of teeth or dentures. Can also include preparation and cleaning of areas used during personal care activities such as the bathroom and kitchen.

c) Routine housecleaning and housekeeping activities performed for a participant that are not associated with the provision of personal care services. Routine home care consists of housework tasks that take place on a daily, weekly or other regular basis, including: washing dishes, laundry, dusting, vacuuming, meal preparation and shopping for food (where no feeding of the participant is involved); other shopping and similar activities that do not involve hands-on care of the participant.

d) Services that provide observation of the participant to assure safety, oversight direction of the participant to complete activities of daily living, instrumental activities of daily living, or companionship for the participant (does not include hands-on care as provided under personal care).

Providers may be members of the individual's family other than a spouse or parent of a minor child. Family members must meet the same standards as other supportive home care providers.

e) Skilled nursing services identified as needed in a participant's plan of care, but that exceed the level of services that have been prior authorized for or are otherwise unavailable to the participant under the state plan.

B. The following list of services are State Plan services included in the Family Care benefit package with definitions as noted in the reference(s) following each service:

- AODA day treatment services defined in HFS 107.13 (in all settings)
- AODA services defined in HFS 107.13 (not inpatient or physician provided)
- Case management defined in HFS 107.32 (includes assessment and care planning)
- Community support program defined in HFS 107.13 (6)
- Durable medical equipment defined in HFS 107.24 (except hearing aids and prosthetics)
- Home Health as defined in HFS 107.11
- Medical supplies defined in HFS 107.24

- Mental health day treatment services defined in HFS 107.13 (in all settings)
- Mental health services defined in HFS 107.13 (not inpatient or physician provided)
- Nursing facility defined in HFS 107.09 including ICF/MR and IMD. Inpatient services are not covered for IMD residents between the ages of 21 years and 64 years of age, except that services may be provided to a 21 year old resident of an IMD if the person was a resident immediately prior to turning 21 and continues to be a resident after turning 21.
- Nursing services defined in HFS 107.11, 107.113 and 107.12 (including respiratory care, intermittent and private duty nursing)
- Occupational therapy defined in HFS 107.17 (in all settings except inpatient hospital)
- Personal care defined in HFS 107.112
- Physical therapy defined in HFS 107.16 (in all settings except inpatient hospital)
- Speech/language pathology defined in HFS 107.18 (in all settings except inpatient hospital)
- Transportation services defined in HFS 107.23 (except ambulance and common carrier)

**Note:** Services defined under s. 49.46 (2) Stats., and HFS 107 Wis. Adm. Code, may be further clarified in all Wisconsin Medicaid Program Provider Handbooks and Bulletins, CMO Contract Interpretation Bulletins (CIBS) and as otherwise specified in this contract.